

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND#19b Per FH

For AMEND#4b per Phy

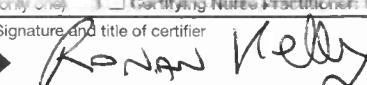
State of Maryland / Department of Health and Mental Hygiene

1- State Registrar 4/25/2012 A&amp;O HEALTH DEPT. CMH

Certificate of Death

2012 15001

Reg. No.

|  |  |   |                               |   |  |  |   |  |  |   |  |                                    |
|--|--|---|-------------------------------|---|--|--|---|--|--|---|--|------------------------------------|
| <b>Physician/<br/>Medical<br/>Examiner</b> |  | 1. Decedent's Name (First, Middle, Last)<br><b>NANCY STEPHEN Mitch WETZEL</b>   |                               |   |  |  |   |  | 2. Date of Death<br>Month <b>04</b> Day <b>19</b> Year <b>2012</b> |   |  | 3. Time of Death<br><b>1:40p M</b> |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>1717-B ST. MARGARET'S ROAD</b>   |                               |   | 4b. City, Town, or Location of Death<br><b>ARNOLD Annapolis</b>  |  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>                     |  |   |  |                                    |
| <b>Funeral<br/>Director</b>                |  | 5. Social Security Number<br><b>232-62-6002</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months      Days  | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/6/1940</b>      | 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b>   |   |  |                                    |
| <b>To Be Completed by Funeral Director</b> |  | 10a. State<br><b>FLORIDA</b>  | 10b. County<br><b>VOLUSIA</b> | 10c. City, Town or Location<br><b>ORMOND BEACH</b>  |  |  |   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                    |
|  |  | 10e. Street and Number<br><b>1024 HAMPSTEAD LANE</b>  |                               |   | 10f. Zip Code<br><b>32174</b>  |  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>          |  |   |  |                                    |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |                                    |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |                               |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 5+</b>          |  |   | 16b. Kind of Business/Industry<br><b>TEACHER EDUCATION</b>     |  |   |  |                                    |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>CECIL STEPHEN</b>   |                               |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RHEA TRENUM</b>   |  |  |   |  |                                    |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>REBECCA MITCH MCKEE/DAUGHTER</b>   |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1717-B ST. MARGARET'S ROAD ANNAPOLIS, MD 21012</b> |  |   |  |  |   |  |                                    |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>CHESAPEAKE CREMATION CENTER</b>   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER</b>  |  |  | Date<br><b>4/24/2012</b>  | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b> |  |   |  |                                    |
|  |  | 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>LASTING TRIBUTES BY FELLOWS<br/>HELFENBEIN &amp; NEWMAN CREMATION &amp; FUNERAL CARE<br/>814 BESTGATE ROAD ANNAPOLIS, MD 21401</b>   |  |  |   |  |  |   |  |                                    |
| <b>Physician/<br/>Medical<br/>Examiner</b> |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | <p>a. Due to (or as a consequence of):<br/><b>STAGE IV Non small CELL LUNG CANCER</b></p> <p>b. Due to (or as a consequence of):<br/><b>METASTATIC Disease with livermet, brain met and bone met</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | Approximate Interval Between Onset and Death<br><b>3 months</b>   |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | 23b. If female:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |                               | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |                                    |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA  |  |  | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |                                    |
|  |  | 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b>   |                               | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |   |  |                                    |
|  |  |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |                                    |
|  |  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | 29b. Signature and title of certifier<br>  |                               | 29c. License number<br><b>072295</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/23/12</b>   |  |  |   |  |                                    |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ronan Kelly, The Bunting Blaustein Cancer Research Building, 1650 Orleans Street, Room G-93, Baltimore, MD 21230</b>   |                               |   |  |  |   |  |  |   |  |                                    |
|  |  | 31. Date filed (Month, Day, Year)<br><b>APR 25 2012</b>   |                               | 32. Registrar's Signature<br>  |  |  |   |  |  |   |  |                                    |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15002

Reg. No.

1 - For State Registrar

|  |  |   |  |   |                                |  |   |  |
|--|--|---|--|---|--------------------------------|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Donna Mary Walker</b>   |   |  |   |                                | 2. Date of Death<br>Month Day Year<br><b>04-22-2012</b>                        | 3. Time of Death<br><b>11:30 A M</b>                            |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>612 Chapel Heights</b>  |   |  |   |                                | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>                  | 4c. County of Death<br><b>Harford</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>195-46-6624</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>56 Yrs.</b>   | If Under 1 Year<br>Months Days Hours Min.   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>08-25-1955</b>                    | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|  | 10a. State<br><b>Maryland</b>  |   |  |   |                                | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Havre de Grace</b>            |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>612 Chapel Heights</b>  |   |  |   |                                | 10f. Zip Code<br><b>21078</b>  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input type="checkbox"/> No Specify:<br><b>White</b> |   |                                |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 1+ Manager</b>  |   |                                |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>             |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Donald Easter</b>  |   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Donnelly</b> |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Walker (Husband)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>612 Chapel Heights Havre de Grace, MD 21078</b>  |   |                                |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► 853001</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harford Mem. Gdns</b>   |   | Date<br><b>04-26-2012</b>      | 20c. Location - City or Town, State<br><b>Aberdeen, MD</b>                     |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>► 853001</b>   |   |  | 22. Name and Address of Facility<br><b>Zellman Funeral Home, P.A.<br/>123 S. Washington St., Havre de Grace, MD</b> |                                |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>acute myocardial infarction</b><br>Approximate Interval Between Onset and Death   |   |  |   |                                |  |   |  |
|  | 23b. If female:<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |   |  |   |                                |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |                                |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |                                |  |   |  |
|  | 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b><br>28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. Signature and title of certifier<br><b>Thomas A. Biondo</b><br>29c. License number<br><b>342800</b><br>29d. Date signed (Month, Day, Year)<br><b>4/25/12</b> |   |  |   |                                |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas A. Biondo, 251 Lewis Ave, Havre de Grace, MD, 21078</b>  |   |  |   |                                |  |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |   | 32. Registrar's Signature<br><b>Leanne P. Jones</b>  |   |                                |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12-02955

James Howard Wallace

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15003

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

|   |   |  |  |  |  |  |   |
|---|---|--|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Howard Wallace</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br>April 15, 2012   |  |  | 3. Time of Death<br>1523 hrs                          |
| 4a. Facility Name (if not institution, give street and number)<br><b>Union Hospital</b>   |   |  | 4b. City, Town, or Location of Death<br><b>Cecil</b>   |  |  | 4c. County of Death<br><b>Cecil</b>                      |   |
| 5. Social Security Number<br><b>212-50-5348</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>64</b>  | Yrs.   | If Under 1 Year<br>Months Days   | If Under 24Hrs.<br>Hours Min.                        | 8. Date of Birth (MM/DD/YYYY)<br><b>4/10/1948</b>        | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
| Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Cecil</b> 10c. City, Town or Location<br><b>Elkton</b>   |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
| 10e. Street and Number<br><b>365 River Road</b>   |   |  | 10f. Zip Code<br><b>21921</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>    |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <b>White</b> |  |  | 14. Race - American Indian, Black, White, etc.           |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>2</b> Quality Control Inspector |  |  | 16b. Kind of Business/Industry<br><b>Jet Engines</b> |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Randolph L. Wallace</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carolyn Jones</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Wallace/wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>365 River Road, Elkton, MD 21921</b> |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>Jane C. M. Johnson</i> |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Elkton Cemetery</b>   |  | Date<br><b>4/20/2012</b>                             | 20c. Location - City or Town, State<br><b>Elkton, MD</b> |   |
| 21. Signature of Funeral Service Licensee<br><i>Jane C. M. Johnson</i>  |   |  | 22. Name and Address of Facility<br><b>259 E. Main Street<br/>R.T. Foard Funeral Home, P.A. Elkton, MD 21921</b>   |  |  |  |   |

**Physician  
/Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. Multiple Injuries<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.  |  |  | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |  |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |  |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Apr 15, 2012</b>   |  | 28b. Time of Injury<br><b>1354 hrs</b>   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>Subject operator of motorcycle in collision with vehicle</b>   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Major Road / Highway</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Locust Point Road, Elkton, MD</b> |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29c. License number<br><b>O.C.M.E.</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 16, 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 2012</b>  |  | 32. Registrar's Signature<br><i>Jane C. M. Johnson</i>  |  |  |  |  |

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

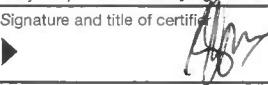
Certificate of Death

Reg. No.

2012 15004

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>01:35 AM  |
| MARGARETTA CHEVERS WHITE   |  | APRIL 22 2012   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>170 ELKMORE ROAD</b>  |  | 4b. City, Town, or Location of Death<br><b>ELKTON</b>   |   | 4c. County of Death<br><b>CECIL</b>   |
| 5. Social Security Number<br><b>194-18-0265</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>87 Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>SEPT. 3, 1924</b>   |
| Usual Residence of Decedent<br><b>MARYLAND CECIL</b>   |  | 10c. City, Town or Location<br><b>ELKTON</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>CECIL</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br><b>170 ELKMORE ROAD</b>  |  | 10f. Zip Code<br><b>21921</b>   |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   | 16b. Kind of Business Industry<br><b>OWN HOME</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD CHEVERS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA STINSON</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARETTA C. DELL/DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>62 DELL LANE, ELKTON, MARYLAND 21921</b>  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, mortuary, or other place)<br><b>NORTH EAST UNITED METHODIST CEMETERY</b>   |   | 20c. Date - Date<br><b>APRIL 25, 2012</b>   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>CROUCH FUNERAL HOME, P.A.</b><br><b>127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901</b>  |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><br>CVA  |   | Approximate Interval Between Onset and Death  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><br>CVA  |   |   |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28d. Describe how injury occurred         |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0062190</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/24/12</b>   |
| 29b. Signature and title of certifier<br>   |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHAHNAWAZ KITAN<br/>2533 AUGUSTINE HERMAN Hwy SUITE A, CHESAPEAKE CITY, MD 21915</b>  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 2012</b>  |  | 32. Registrar's Signature<br>  |   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15005

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  |   | 2. Date of Death<br>Month Day Year   |   |  |   | 3. Time of Death<br>8:15PM M                                      |   |  |
| <b>Gladys Jones Ward</b>   |  |   | <b>April 19, 2012</b>  |   |  |   |   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>2810 North Matthews Road</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Bryans Road</b>   |   |  |   | 4c. County of Death<br><b>Charles</b>                             |   |  |
| 5. Social Security Number<br><b>241-10-0215</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 2, 1916</b> | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b> |   |  |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Charles</b>   |  | 10c. City, Town or Location<br><b>Bryans Road</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>X</b> |  |
| 10e. Street and Number<br><b>2810 North Matthews Road</b>  |  |   | 10f. Zip Code<br><b>20616</b>  |   |  |   | 10g. Citizen of What Country?<br><b>United States</b>             |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                 |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Representative</b>      |   |  |   | 16b. Kind of Business/Industry<br><b>Retail</b>                   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hamilton Jones</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Della Morrison</b> |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Randy Ward (Son)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4425 Danville Road Brandywine, MD. 20613</b> |   |  |   |   |   |  |

|   |   |                          |   |
|---|---|--------------------------|---|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Memorial</b>         | Date<br><b>4/27/2012</b> | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br>  | 22. Name and Address of Facility<br><b>Huntt Funeral Home 3035 Old Washington Road Waldorf, MD. 20601</b> |                          |   |

|  |  |  |
|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | Approximate Interval Between Onset and Death |
| a. <br>Due to (or as a consequence of):  |  |  |
| b. _____<br>Due to (or as a consequence of):   |  |  |
| c. _____<br>Due to (or as a consequence of):   |  |  |
| d. _____   |  |  |

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |  |  |  |
|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |

|   |   |  |
|---|---|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA | Other:<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|---|---|--|

|  |  |                          |  |  |
|--|--|--------------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
| 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |                                      |  |  |   |
|--|--------------------------------------|--|--|---|
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br><b>D28352</b> |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/12</b> |
|--|--------------------------------------|--|--|---|

|   |   |  |
|---|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Krishan Mathur P.O. Box 1703 La Plata, MD. 20646</b> | 31. Date filed (Month, Day, Year)<br><b>APR 25 2012</b> | 32. Registrar's Signature<br> |
|---|---|--|

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15006

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |   |  |  |  |  |                           |   |   |  |   |                              |
|---|--|---|---|--|--|--|--|---------------------------|---|---|--|---|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lucy Paulette Wilson</b>   |  |   |   |  |  |  |  |                           |   |   |  | 2. Date of Death<br>Month 04 Day 13 Year 2012   | 3. Time of Death<br>1:14 P M |
| 4a. Facility Name (if not institution, give street and number)<br><b>Garrett Memorial Hospital</b>  |  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>   |  |                           |   | 4c. County of Death<br><b>Garrett</b>                       |  |   |                              |
| 5. Social Security Number<br><b>267-13-7854</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> |   | 7. Age (In yrs. last birthday)<br><b>58 Yrs.</b> |  | If Under 1 Year<br>Months  |  | If Under 24 Hrs.<br>Hours |   | 8. Date of Birth<br>(Month, Day, Year)<br><b>07/04/1953</b> |  | 9. Birthplace (State or Foreign Country)<br><b>FL</b>   |                              |
| 10a. State<br><b>WV</b>   |  | 10b. County<br><b>Preston</b>   |   | 10c. City, Town or Location<br><b>Eglon</b>      |  |  |  |                           |   |   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                              |
| 10e. Street and Number<br><b>4503 Central Trail Road</b>  |  |   |   |  |  | 10f. Zip Code<br><b>26716</b>  |  |                           |   | 10g. Citizen of What Country?<br><b>USA</b>                 |  |   |                              |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White</b> |  |                           | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |   |  |   |                              |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |   |   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |                           |   | 16b. Kind of Business/Industry<br><b>Homemaking</b>         |  |   |                              |
| 17. Father's Name (First, Middle, Last)<br><b>Vester P. Jefferys</b>  |  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucille Unknown</b>  |  |                           |   |   |  |   |                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald L. Wilson / Husband</b>   |  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4503 Central Trail Road, Eglon, WV 26716</b>   |  |                           |   |   |  |   |                              |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b> |  |   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Terra Alta</b>  |  | Date<br><b>4/16/2012</b>  | 20c. Location - City or Town, State<br><b>Terra Alta, WV</b>            |   |  |   |                              |
| 21. Signature of Funeral Service Licensee<br><b>Ronald L. Wilson</b>  |  |   |   |  |  | 22. Name and Address of Facility<br><b>Burdock-Fredlock Funeral Home, P.A., 21 North Second Street, Oakland, MD 21550</b>  |  |                           |   |   |  |   |                              |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Baltimore, Maryland 21215-0036**

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760

|   |  |  |                          |  |                                   |
|---|--|--|--------------------------|--|-----------------------------------|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | Approximate Interval Between Onset and Death<br><b>2 HRS</b>   |                          |  |                                   |
| <p>a. <u>Complete Heart Block</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Cardiomyopathy</u><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |                          |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br/>9 <input type="checkbox"/> Unknown</b> |                          |  |                                   |
|   |  | 23d. Date of delivery<br>Month Day Year  |                          |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                          |  |                                   |
| Malnutrition  |  |  |                          |  |                                   |
| Severe Pneumonia  |  |  |                          |  |                                   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>  |                          |  |                                   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | 28d. Describe how injury occurred |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                           |                                   |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D23979</b>   |                          | 29d. Date signed (Month, Day, Year)<br><b>April 17, 2012</b>   |                                   |
| 29b. Signature and title of certifier<br><b>Ronald A. Goralski</b>  |  |  |                          |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |  |                          |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 2012</b>   |  | 32. Registrar's Signature<br><b>Laura J. Goralski</b>  |                          |  |                                   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15007

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |                                |  |            |   |         |   |  |                                   |  |
|--|--|---|--------------------------------|--|------------|---|---------|---|--|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death  |                                |  |            | 3. Time of Death  |         |   |  |                                   |  |
| Richard Gilbert Winger, Sr   |  | Month   | Day                            | Year   | 04 25 2012 |   | 8:45 PM |   |  |                                   |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |                                |  |            | 4c. County of Death   |         |   |  |                                   |  |
| Julia Manor Healthcare Center  |  | Hagerstown  |                                |  |            | Washington  |         |   |  |                                   |  |
| 5. Social Security Number  |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year  |            | 8. Date of Birth (Month, Day, Year)   |         | 9. Birthplace (State or Foreign Country)  |  |                                   |  |
| 213-30-1491  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 81 Yrs.                        | Months   | Days       | Hours   | Min.    | Jan. 26, 1931 Maryland  |  |                                   |  |
| Usual Residence of Decedent  |  | 10a. State 10b. County 10c. City, Town or Location  |                                |  |            | 10d. Inside City Limits   |         | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  |  |                                   |  |
| Maryland Washington County Hagerstown  |  |   |                                |  |            | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |         | 16922 Stoneybrook Terrace 21740 U.S.A.  |  |                                   |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |            |   |         | 14. Race - American Indian, Black, White, etc. Specify: White   |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.   |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |            |   |         |   |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                |  |            | 16b. Kind of Business/Industry  |         | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)   |  |                                   |  |
| Elementary/Secondary (0-12) 12   |  | Salesman  |                                |  |            | Office Supply Co.   |         | William Daryl Winger, Sr. Mary Emma Gilbert   |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |            | Date  |         | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State             |  |                                   |  |
| Nancy C. Winger-wife   |  | 16922 Stoneybrook Terrace Hagerstown, MD 21740  |                                |  |            | Cedar Lawn Mem. Park 5-1-2012 Hagerstown, MD  |         |   |  |                                   |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility  |                                |  |            | Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742   |         |   |  |                                   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)                                  |                                |  |            | Approximate Interval Between Onset and Death  |         |   |  |                                   |  |
| 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | a. Due to (or as a consequence of): <u>Vascular Dementia with Behavioral Disturbance</u>  |                                |  |            |   |         |   |  |                                   |  |
| {  |  | b. Due to (or as a consequence of): <u>Parkinson's Disease</u>  |                                |  |            |   |         |   |  |                                   |  |
| 23d. Date of delivery Month Day Year   |  | c. Due to (or as a consequence of): <u>Insulin Dependent Diabetes Mellitus</u>  |                                |  |            |   |         |   |  |                                   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | d. Due to (or as a consequence of): <u>Atherosclerotic Cardiovascular Disease</u>   |                                |  |            |   |         |   |  |                                   |  |
| 23f. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23g. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                                |  |            | 23h. Date of delivery Month Day Year  |         |   |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |            | 24c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown        |         |   |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |                                |  |            | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined |         | 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |            |   |         |   |  |                                   |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><u>Barbara Nader-Blucher CRNP</u>  |                                | 29c. License number<br>R125360   |            | 29d. Date signed (Month, Day, Year)<br>4/25/12  |         |   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  | 31. Date filed (Month, Day, Year)<br>APR 30 2012  |                                | 32. Registrar's Signature<br><u>JW-6</u>   |            |   |         |   |  |                                   |  |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15008

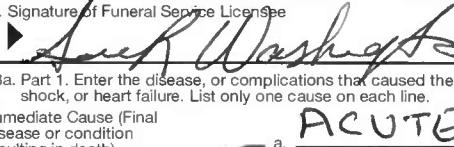
For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0336  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|   |   |   |  |   |
|---|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Katherine A. Weiss</b>   |   |   | 2. Date of Death<br>Month April Day 22, Year 2012  | 3. Time of Death<br>5:45 a M                                |
| 4a. Facility Name (if not institution, give street and number)<br><b>Hyattsville Heartland Health Care Ctr of</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>   | 4c. County of Death<br><b>Prince George's</b>               |
| 5. Social Security Number<br><b>216-64-5698</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b><br>Yrs.   | If Under 1 Year<br>Months<br>Days<br>Hours<br>Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>08-19-1954</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Cheverly, MD</b>   |   |   | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 11. Usual Residence of Decedent<br><b>MD Prince George's</b>  |   | 10b. State<br><b>MD</b> 10c. City, Town or Location<br><b>Bladensburg</b>   |  |   |
| 10e. Street and Number<br><b>4112 53rd Ave Apt #6</b>   |   |   | 10f. Zip Code<br><b>20710</b>  | 10g. Citizen of What Country?<br><b>United States</b>       |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b> |  | 16b. Kind of Business Industry<br><b>Private</b>            |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Weiss</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Chroniger</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra Weiss/Sister</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4112 53rd Ave Apt#6 Bladensburg, MD 20710</b>  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   | Date<br><b>04-27-2012</b>                                   |
| 21. Signature of Funeral Service Licensee<br>   |   |   | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>  |   |
| 22. Name and Address of Facility<br><b>Fort Lincoln Funeral Home<br/>3401 Bladensburg Rd Brentwood, MD 20722</b>  |   |   |  |   |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |                          |  |
|--|--|---|--------------------------|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <b>ACUTE RESPIRATORY FAILURE</b>  |                          | Approximate Interval Between Onset and Death   |
| a. Due to (or as a consequence of):<br><b>CARDIAC ARRHYTHMIA</b>   |  |   |                          |  |
| b. Due to (or as a consequence of):<br><b>BACTERIAL PNEUMONIA</b>  |  |   |                          |  |
| c. Due to (or as a consequence of):<br><b>ACUTE RENAL FAILURE</b>  |  |   |                          |  |
| d. Due to (or as a consequence of):  |  |   |                          |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |                          | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ANEMIA</b>  |  |   |                          | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |                          | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28d. Describe how injury occurred  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                          |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>MD52855</b>   |                          | 29d. Date signed (Month, Day, Year)<br><b>4-25-2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chanbra Korapat MD. 720.5 Hanover Parkway suite B Greenbelt, MD 20770</b>   |  |   |                          |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 2012</b>  |  | 32. Registrar's Signature<br>  |                          |  |

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

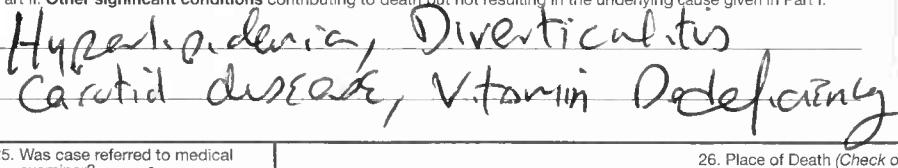
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15009

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
|--|--|--|--|---|--|-------------------------------------|---|--|---|-----|------|---|--------|--|----|--|-------|--|----|--|--|--|----|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  |  | 2. Date of Death   |   |  |                                     | 3. Time of Death  |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Jerry Lee Williams   |  |  | Month April Day 20 Year 2012   |   |  |                                     | 5:47 A M  |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  |  | 4b. City, Town, or Location of Death   |   |  |                                     | 4c. County of Death   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Southern Maryland Hospital   |  |  | Clinton  |   |  |                                     | Prince George's   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 5. Social Security Number  |  | 6. Sex   | 7. Age (In yrs. last birthday)   | If Under 1 Year   | If Under 24 Hrs.   | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country)                                |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 525-66-6610<br>Usual Residence of Decedent   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 76 Yrs.  | Months  | Days   | Hours Min.                          | Oct. 4, 1935<br>New Mexico  |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 10a. State   |  | 10b. County  |  | 10c. City, Town or Location   |  |                                     |   |  | 10d. Inside City Limits   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Maryland   |  | Prince George's  |  | Temple Hills  |  |                                     |   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 10e. Street and Number   |  |  |  | 10f. Zip Code   |  |                                     |   | 10g. Citizen of What Country?                                    |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 3806 Matthews Drive  |  |  |  | 20748   |  |                                     |   | USA  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 1955-<br>If Yes, Give Year or Dates.<br>58  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)  |  | Elementary/Secondary (0-12)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)                                    |                                     |   | 16b. Kind of Business/Industry                                   |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Ross A. Williams -Son  |  | College (1-4 or 5+)  |  |   | Program Analyst  |                                     |   | Federal Government   |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 17. Father's Name (First, Middle, Last)  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Jerry Lee Williams , Sr.   |  |  |  | Bonnie Evelyn Eaker   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Ross A. Williams -Son  |  |  |  | 15808 Baden Westwood Rd., Brandywine, MD 20613  |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 20a. Method of Disposition   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                        |  |                                     | Date  | 20c. Location - City or Town, State                              |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | Kalas Crematory   |  |                                     | 4/21/2012   | Edgewater, MD  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 21. Signature of Funeral Service Licensee  |  |  |  | 22. Name and Address of Facility  |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
|   |  |  |  | George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd., Oxon Hill, MD 20745                 |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| <table border="1"> <tr> <td>a.</td> <td>Stomach Bleed<br/>Due to (or as a consequence of):</td> <td>24 hrs</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Atrial f.ibrillation<br/>Due to (or as a consequence of):</td> <td>3 yrs</td> <td></td> </tr> <tr> <td>c.</td> <td>Hypertensive heart disease<br/>Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>   |  |  |  |   |  |                                     |   |  |   |     | a.   | Stomach Bleed<br>Due to (or as a consequence of): | 24 hrs | Approximate Interval Between Onset and Death | b. | Atrial f.ibrillation<br>Due to (or as a consequence of): | 3 yrs |  | c. | Hypertensive heart disease<br>Due to (or as a consequence of): |  |  | d. |  |  |  |
| a.   | Stomach Bleed<br>Due to (or as a consequence of):              | 24 hrs   | Approximate Interval Between Onset and Death   |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| b.   | Atrial f.ibrillation<br>Due to (or as a consequence of):       | 3 yrs  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| c.   | Hypertensive heart disease<br>Due to (or as a consequence of): |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| d.   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| IF FEMALE:   |  | 23c. If yes, outcome of pregnancy  |  |   |  |                                     |   |  | 23d. Date of delivery   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |   |  |                                     |   |  | Month   | Day | Year |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
|    |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |  |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 27. Manner of Death  |  |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury  |                                     | 28c. Injury at work?  |  | 28d. Describe how injury occurred                                       |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  |  | M  |   |  |                                     | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  | 29c. License number  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
|   |  |  | D47748   |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 29b. Signature and title of certifier  |  |  | 29d. Date signed (Month, Day, Year)  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
|   |  |  | 4/20/2012  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |  |  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| John P. Holmes, MD 7501 Surratts Road Suite 302 Clinton  |  |  | MD 20759   |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| 31. Date filed (Month, Day, Year)  |  |  | 32. Registrar's Signature  |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |
| APR 8 2012   |  |  |   |   |  |                                     |   |  |   |     |      |   |        |  |    |  |       |  |    |  |  |  |    |  |  |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

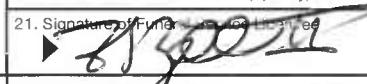
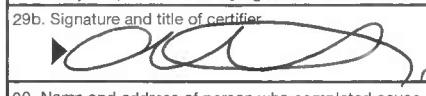
Certificate of Death

Reg. No.

2012 15010

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Doris Jean Wise</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>1</b> , Year <b>2012</b>  |  | 3. Time of Death<br><b>9:00 PM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>312 Strawberry Lane Apt. 3</b>  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>   |  | 4c. County of Death<br><b>Harford</b>  |
| 5. Social Security Number<br><b>218-46-1304</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>63 Yrs.</b>   | If Under 1 Year<br>Months      If Under 24 Hrs.<br>Days      Hours      Min.   |
| Usual Residence of Decedent<br><b>Maryland Harford</b>   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/10/1948</b>   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Havre de Grace</b>   |  |
| 10e. Street and Number<br><b>312 Strawberry Lane Apt. 3</b>  |  | 10f. Zip Code<br><b>21078</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.<br><b>Year or Dates.</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Hairdresser</b>  |  | 16b. Kind of Business/Industry<br><b>Beautician</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>David Martin</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Hinder</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Sarver (friend)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 Strawberry Lane Apt. 3, Havre de Grace MD 21078</b>   |  |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RA Ferris &amp; Co Inc</b>   | Date<br><b>05/04/2012</b>  | 20c. Location - City or Town, State<br><b>West Chester, Pennsylvania</b>   |
| 21. Signature of Funeral Director (Last, First, Middle Initials)<br>  |  | 22. Name and Address of Facility<br><b>Zellman Funeral Home, P.A.<br/>123 S. Washington St. Havre de Grace, MD</b>  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b>   |  | Approximate Interval Between Onset and Death<br><b>Weeks</b>  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):<br><b>Lung Cancer</b>   |  |  |
|  |  | b. Due to (or as a consequence of):   |  |  |
|  |  | c. Due to (or as a consequence of):   |  |  |
|  |  | d. _____  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>9 <input checked="" type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>      |  | 23d. Date of delivery<br>Month      Day      Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br><b>M</b>  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |  |  |
| 29b. Signature and title of certifier<br><br><b>A. Poppe Ries</b>   |  | 29c. License number<br><b>DO065827</b>  | 29d. Date signed (Month, Day, Year)<br><b>5/2/12</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. Poppe Ries 500 Upper Chesapeake Dr Bel Air MD 21014</b>  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

2 Jan

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 1501

1 - For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie York

2. Date of Death

Month

Day

Year

3. Time of Death

April 18th 2012

8:35 p<sup>m</sup>

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

CHARLOTTE HALL VETERANS HOME

4b. City, Town, or Location of Death

CHARLOTTE HALL

4c. County of Death

CHARLES COUNTY

Funeral Director

5. Social Security Number

251-44-9072

6. Sex

M

F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

Month

Day

Year

11/24/1929

9. Birthplace (State or Foreign Country)

Sumter S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Charles County

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

 Yes  No

10e. Street and Number

29449 Charlotte Hall Road

10f. Zip Code

20622

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Date 2/2/1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Pearson York

18. Mother's Name (First, Middle, Maiden Surname)

Luvenia Hudson

19a. Informant's Name/Relationship (Type, Print)

Rosanna York/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20032

614 Galveston Place S.E. Washington, DC

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans

Date

20c. Location - City or Town, State

04/25/2012 Cheltenham Maryland

21. Signature of Funeral Service License

MO1476

22. Name and Address of Facility 5635 Eads Street NE Wash, DC

Tyrone J. Young Funeral Services 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ED Stage Alzheimer's Dementia

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Hypertensive Heart Disease

Hyperlipidemia

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was cause referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  D.O.A.

26. Place of Death (Check only one)

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen Casserty MD

29c. License number

H0037228MD

29d. Date signed (Month, Day, Year)

4/24/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Casserty MD. 29449 Charlotte Hall Rd Charlotte Hall MD 20622

31. Date filed (Month, Day, Year)

APR 26 2012

32. Registrar's Signature

Stephen J. York

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15012

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

|  |  |   |   |   |  |   |  |  |   |                                     |  |
|--|--|---|---|---|--|---|--|--|---|-------------------------------------|--|
| Physician/<br>Medical<br>Examiner                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Aldo William Zanzi</b>   |   |   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>21</b> Year <b>2012</b>  |   | 3. Time of Death<br><b>6:09 p M</b> |  |
| Funeral<br>Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>8035 Glendale Road</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Chevy Chase</b>   |   |  | 4c. County of Death<br><b>Montgomery</b>   |   |                                     |  |
| To Be Completed by Funeral Director                                |  | 5. Social Security Number<br><b>106-18-1476</b>   | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b>  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 26, 1923</b>              | 9. Birthplace (State or Foreign Country)<br><b>Italy</b>   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                                     |  |
|  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Chevy Chase</b>   |  |  |   |                                     |  |
|  |  | 10e. Street and Number<br><b>8035 Glendale Road</b>   |   |   | 10f. Zip Code<br><b>20815</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |                                     |  |
|  |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>If Yes, Give Year or Dates.<br/><b>WWII</b></b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |                                     |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Economist</b>   |   |  | 16b. Kind of Business/Industry<br><b>International Business</b>  |   |                                     |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Gaetano Zanzi</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Frattini</b>   |   |  |  |   |                                     |  |
| Physician/<br>Medical<br>Examiner                                  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanne D. Zanzi - Spouse</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8035 Glendale Road, Chevy Chase, Maryland 20815</b>  |   |  |  |   |                                     |  |
|  |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>   |   |  | Date<br><b>04/25/2012</b>  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>   |                                     |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Ronald J. Oskoui MO1241</b>   |   |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Ave., Silver Spring, MD 20904</b>  |   |  |  |   |                                     |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |   |   | 23b. Due to (or as a consequence of):<br><b>Ventricular Fibrillation</b>   |   |  | Approximate Interval Between Onset and Death   |   |                                     |  |
|  |  |   |   |   | 23c. Due to (or as a consequence of):<br><b>Renal Insufficiency</b>  |   |  |  |   |                                     |  |
|  |  |   |   |   | 23d. Due to (or as a consequence of):<br><b>Aortic Stenosis</b>  |   |  |  |   |                                     |  |
|  |  |   |   |   | 23e. Due to (or as a consequence of):<br><b>Systemic Hypertension</b>  |   |  |  |   |                                     |  |
|  |  | 23f. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>   |   |   | 23g. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b> |   |  | 23h. Date of delivery<br>Month Day Year  |   |                                     |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   | 23i. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>  |   |  |  |   |                                     |  |
|  |  |   |   |   | 23j. 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |   |                                     |  |
|  |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |   | 26. Place of Death (Check only one)<br><b>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>   |   |  |  |   |                                     |  |
|  |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>  |   |   | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred   |                                     |  |
|  |  |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |                                     |  |
|  |  | 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |   | 29c. License number<br><b>D0040576</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>April 24, 2012</b>   |   |                                     |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ramin Oskoui, M.D., 3301 New Mexico Avenue, #316, Washington, DC 20016</b>   |   |   |  |   |  |  |   |                                     |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |   |   | 32. Registrar's Signature<br><b>Ronald J. Oskoui</b>   |   |  |  |   |                                     |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

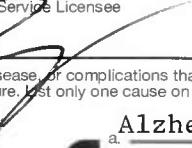
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15013

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Mary Parkhurst Zmudzinski</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>19</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>9:15 PM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Kline Hospice House</b>   |  | 4b. City, Town, or Location of Death<br><b>Mount Airy</b>   |  | 4c. County of Death<br><b>Frederick</b>  |
| 5. Social Security Number<br><b>513-16-1364</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months      Days      Hours      Min.   |
| 8. Usual Residence of Decedent<br><b>Maryland Frederick</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Kansas</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Walkersville</b>   |
| 10e. Street and Number<br><b>123 Challedon Drive</b>   |  | 10f. Zip Code<br><b>21793</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br><b>White</b>  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Editor</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Bert Myron Parkhurst</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olive Verda Wilson</b>  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Teresa Gallion / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 Challedon Dr. Walkersville, MD 21793</b>  |  | 19c. Date of Disposition<br><b>April 21, 2012</b>  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Resthaven Funeral Services, Skkot Cody P.A.<br/>9501 Catoctin Mountain Hwy. Frederick, MD 21701</b>  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's Disease</b> |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month      Day      Year  |
| 24. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br><b>Hospice House</b>  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D-13977</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 20, 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert L. Kaufmann, M.D. 300 West 9th Street, Frederick, MD 21701</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 24 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 5 per fh g927 5-11-12 yr  
 State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No. 2012 15014

|   |   |  |   |   |   |  |  |  |
|---|---|--|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Juanita Ambush</i>   |  |   |   |   | 2. Date of Death<br>Month <i>May</i> Day <i>9</i> Year <i>2012</i>                             | 3. Time of Death<br><i>8:00 P M</i>  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><i>Loch Raven Center</i>  |  | 4b. City, Town, or Location of Death  |   |   | 4c. County of Death<br><i>Baltimore</i>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>216-40-5317</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>89</i><br>Yrs.   | If Under 1 Year<br>Months <i>0</i> Days <i>0</i>                            | If Under 24 Hrs.<br>Hours <i>0</i> Min. <i>0</i>  | 8. Date of Birth<br>(Month, Day, Year)<br><i>11/20/1922</i>                                    | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                |  |
|   | Usual Residence of Decedent<br>10a. State <i>MD</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><i>8720 Emge Road</i>   |  |   | 10f. Zip Code<br><i>21234</i>   |   | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i>Black</i> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><i>Black</i> |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Seconday (0-12)</i>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Janitor</i>  |   | 16b. Kind of Business Industry<br><i>Baltimore County Schools</i>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Jessie Ambush</i>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Genevieve Smith</i> |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <i>Daughter</i><br><i>Ms. Emily Ambush</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>68 Solar Circle Balt., MD 21234</i>   |   |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Mt. Zion Cemetery</i>  |   | Date <i>5/16/12</i>   | 20c. Location - City or Town, State<br><i>Lansdowne, MD</i>                                    |  |  |
| Physician/<br>Medical<br>Examiner   | 21. Signature of Funeral Service Licensee<br><i>Odyssey Gray</i>  |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home, P.A.<br/>2222 N. North Ave. Balt., MD 21216</i>   |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Debility</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Kidney failure</i><br>Approximate Interval Between Onset and Death<br><i>months</i>  |  |   |   |   |  |  |  |
|   | b. Due to (or as a consequence of):<br><i>Kidney failure</i><br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |   |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>End-stage chronic kidney disease</i> |   |  |   |   |   |  |  |  |
|   |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown            |  |  |  |
|   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |   |  |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |  |  |
|   | 29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one) <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Karen J. Jennings CRN</i>   |  |   |   |   |  |  |  |
|   | 29c. License number<br><i>R086520</i>   |  |   |   |   |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br><i>May 9, 2012</i>   |  |   |   |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>   |  | 32. Registrar's Signature<br><i>Susan J. Parker</i>   |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|                    |  |
|--------------------|--|
| State<br>Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Karen Jennings CRN 6095 Marshalee Drive Elkhenge Md 21085</i> |
|--------------------|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15015

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Robert Anderson 5/7/2012 4:00pm  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral  
Director

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>0409 M  |
| <i>Robert Anderson</i>   |  | May 7 2012  |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><i>Suburban Hospital</i>   |  | 4b. City, Town, or Location of Death<br><i>Bethesda</i>   |   | 4c. County of Death<br><i>Montgomery</i>  |
| 5. Social Security Number<br><i>271-52-4028</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>60 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br><i>March 2, 1952</i>  |
| 9. If Under 1 Year<br>Months Days  |  | 10. If Under 24 Hrs.<br>Hours Min.  |   | 9. Birthplace (State or Foreign Country)<br><i>Ohio</i>   |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Montgomery</i>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br><i>19410 Transhire Road</i>  |  | 10f. Zip Code<br><i>20886</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><i>White</i> |
| 14. Race - American Indian, Black, White, etc.<br><i>White</i>   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 12</i>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Computer Programmer</i>  |
| 16b. Kind of Business/Industry<br><i>Civil Service</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Carl Anderson</i>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Catherine McDermott</i>   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Aileen B. Anderson (Wife)</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>19410 Transhire Rd., Montgomery Village, MD 20886</i>   |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>Metropolitan Crematory</i>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Metropolitan Crematory</i>   |   | 20c. Date<br><i>5/9/2012</i>  |
| 21. Signature of Funeral Service Licensee<br><i>Deanna Bhattacharya</i>  |  | 22. Name and Address of Facility<br><i>Metropolitan Funeral Service<br/>5517 Vine St., Alexandria, VA 22310</i>   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><i>H117 Fracture</i>   |   | Approximate Interval Between Onset and Death<br><i>mom 2d</i>   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><i>Fracture due to fall</i>  |   |   |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><i>myocardial infarction</i>  |   |   |
| 23f. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown         |   | 23d. Date of delivery<br>Month Day Year   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><i>Home</i> |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                  |
| 27. Manner of Death<br><input type="checkbox"/> Natural<br><input checked="" type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><i>4/26/12</i>   |   | 28b. Time of injury<br><i>unk M</i>   |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><i>Fall</i>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>Home</i>   |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><i>D 68484</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>5/7/12</i>  |
| 29b. Signature and title of certifier<br><i>Timothy Bhattacharyya, M.D.</i>  |  | 29c. License number<br><i>D 68484</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>5/7/12</i>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Timothy Bhattacharyya, M.D. 8600 Old Georgetown Rd., Bethesda, Maryland</i>   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>  |  | 32. Registrar's Signature<br><i>Deanna B. Bhattacharya</i>  |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15016

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

DHMH 17 Rev 06-2011

|   |  |   |   |                                |  |   |   |  |  |  |  |
|---|--|---|---|--------------------------------|--|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | Josephine Belvin  |   |                                |  | 2. Date of Death<br>Month<br>May  | Day<br>1 2012   | Year<br>6:35 PM  | 3. Time of Death<br>6:35 PM  |  |  |
| 4a. Facility Name (if not institution, give street and number)  |  | Season's Hospice Center   |   |                                |  | 4b. City, Town, or Location of Death<br>Randallstown  |   | 4c. County of Death<br>Baltimore   |  |  |  |
| 5. Social Security Number<br>215-14-5983  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>88 Yrs. | If Under 1 Year<br>Months<br>0 | If Under 24 Hrs.<br>Days<br>0  | Hours<br>0  | Min.<br>0   | 8. Date of Birth<br>(Month, Day, Year)<br>June 29, 1923                      | 9. Birthplace (State or Foreign Country)<br>North Carolina                                     |  |  |
| Usual Residence of Decedent<br>MD   |  | 10a. State<br>MD  |   | 10b. County<br>N/A             |  | 10c. City, Town or Location<br>Baltimore  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>2022 N. Bentallow St.   |  |   |   |                                |  | 10f. Zip Code<br>21216  |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify: Black  |   |  |  | 14. Race - American Indian, Black, White, etc. |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) 0   |   |                                |  | 16b. Kind of Business/Industry<br>Manufacturing   |   |  |  | Car Company                                    |  |
| 17. Father's Name (First, Middle, Last)<br>Earlie Wilder (Son)  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>unk  |   |                                |  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Willie Belvin Jr.   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2022 N. Bentallow St. Baltimore, MD 21216  |   |                                |  |   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest   |   |                                |  | Date<br>5/7/2012  | 20c. Location - City or Town, State<br>Owings Mills, MD |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>► Odyssey Gray   |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home, P.A.<br>2225 W. North Ave. Baltimore, MD 21216   |   |                                |  |   |   |  |  |  |  |
| 23a. Part 1: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part 1: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |   |                                |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | {   |   |                                |  | 23d. Date of delivery<br>Month Day Year   |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |                                |  |   |   |  |  |  |  |
| 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |                                |  | 23g. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |   |                                |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br>In-patient hospice   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M       | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |   |  |  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D0057465   |   |                                |  | 29d. Date signed (Month, Day, Year)<br>5/12/12  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>NS Rajapakse MD 2835 Smith Av S203  |  |   |   |                                |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012  |  | 32. Registrar's Signature<br>Sarah S. Parker  |   |                                |  |   |   |  |  |  |  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15017

1 - For  
State  
Registrar

Patient known as Chanti Brisco

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>16:16 PM   |  |
| Chanti Denise Briscoe  |  | May 05 2012   |   |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |  |
| Sini Hospital of Baltimore   |  | Baltimore City  |   |  |  |
| 5. Social Security Number  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>37 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | Date of Birth<br>(Month, Day, Year)<br>11-28-1974  |
| 212-84-1091  |  |   |   |  | Maryland   |
| Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)  |   |  |  |
| MD N/A   |  | USA   |   |  |  |
| 10a. State   |  | 10b. County   | 10c. City, Town or Location               |  |  |
| MD   |  | N/A   | Baltimore                                 |  |  |
| 10e. Street and Number   |  | 10f. Zip Code   |   | 10g. Citizen of What Country?  |  |
| 4347 Reisterstown Road   |  | 21215   |   | USA  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| Elementary/Secondary (0-12) 12   |  | College (1-4 or 5+) 0   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |   | 16b. Kind of Business/Industry<br>Homemaker Home   |  |
| 16. Father's Name (First, Middle, Last)<br>Thomas Daniel   |  | 17. Mother's Name (First, Middle, Maiden Surname)<br>Denise Spence  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ms. Sade Briscoe   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City + Town, State, Zip Code)<br>5721 Karon Ave. Balt., MD 21206   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Carmel Cem.   |   | Date 5/14/12   | 20c. Location - City or Town, State<br>Dundalk, MD |
| 21. Signature of Funeral Service License<br>► Odyssey Gray   |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home, P.A.<br>2222 W. North Ave. Balt., MD 21216   |   |  |  |
| 23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death  |   |  |  |
| a. Due to (or as a consequence of):<br>Acute Respiratory distress syndrome   |  |   |   |  |  |
| b. Due to (or as a consequence of):<br>Shock   |  |   |   |  |  |
| c. Due to (or as a consequence of):<br>Acute Pancreatitis  |  |   |   |  |  |
| d.   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input checked="" type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                                     |   | 23d. Date of delivery<br>Month Day Year  |  |
| 9 <input checked="" type="checkbox"/>  |  | 9 <input type="checkbox"/>  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |  |
| Human Immunodeficiency Virus, Hepatitis C, Diabetes Mellitus, Hypertension, Alcohol abuse, Intravenous drug abuse.   |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred                  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>RES-000  |   |  |  |
| 29b. Signature and title of certifier<br>► [Signature]   |  | 29d. Date signed (Month, Day, Year)<br>May, 05, 2012  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>TAMNA WONGJAM  |  | Sini Hospital of Baltimore  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15018

1 - For  
State  
Registrar

|                                     |  |   |                                     |  |  |  |                           |  |   |   |  |
|-------------------------------------|--|---|-------------------------------------|--|--|--|---------------------------|--|---|---|--|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><i>Colete, Burns</i>  |                                     |  |  |  |                           | 2. Date of Death<br>Month 05 Day 08 Year 2012                        |   | 3. Time of Death<br>9:59 A M  |  |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br><i>University of maryland medical center</i>  |                                     |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i> |  |                           | 4c. County of Death  |   |   |  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br><i>250-29-9513</i>   |                                     | 6. Sex<br><i>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</i>  | 7. Age (In yrs. last birthday)<br><i>50</i><br>Yrs.      | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours | 8. Date of Birth<br>(Month, Day, Year)<br><i>Jan.28,1962</i>         | 9. Birthplace (State or Foreign Country)<br><i>New York</i>   |   |  |
|                                     |  | Usual Residence of Decedent   |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | 10a. State<br><i>Maryland</i>   | 10b. County<br><i>Prince George</i> |  | 10c. City, Town or Location<br><i>Springdale</i>         |  |                           |  | 10d. Inside City Limits<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i> |   |  |
|                                     |  | 10e. Street and Number<br><i>3909 Meadow Hill Road</i>  |                                     |  |  | 10f. Zip Code<br><i>20774</i>  |                           |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |   |  |
|                                     |  | 11. Marital Status<br><i>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</i>  |                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</i> |                           |  | 14. Race - American Indian, Black, White, etc.<br><i>Specify: Black</i>                                   |   |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>  |                                     | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>College (1-4 or 5+)<br/>4 Accountant</i>  |  | 16b. Kind of Business/Industry<br><i>Education</i>   |                           |  |   |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><i>Richard Garland</i>   |                                     |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Rena Roger</i>   |                           |  |   |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Dwayne Burns/Husband</i>   |                                     |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3909 Meadow Hill Road, Springdale, MD 20774</i>  |                           |  |   |   |  |
|                                     |  | 20a. Method of Disposition<br><i>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br/><i>► 6 no more</i></i>  |                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Hillside Memorial</i>   |  | Date<br><i>May14,2012</i>  |                           | 20c. Location - City or Town, State<br><i>Sumter, South Carolina</i> |   |   |  |
|                                     |  | 21. Signature of Burial Service Licensee <i>JOSEPH L. CANBY</i>   |                                     | 22. Name and Address of Facility<br><i>Marzullo Funeral Chapel, P.A.<br/>6009 Harford Road, Baltimore, MD 21214</i>  |  |  |                           |  |   |   |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>► progressive multiple myeloma</i>  |                                     |  |  |  |                           |  |   | Approximate Interval Between Onset and Death  |  |
|                                     |  | a. Due to (or as a consequence of):<br><i>► progressive multiple myeloma</i>  |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | b. Due to (or as a consequence of):   |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | c. Due to (or as a consequence of):   |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | d. Due to (or as a consequence of):   |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</i>  |                                     | 23c. If yes, outcome of pregnancy<br><i>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</i> |  |  |                           |  |   | 23d. Date of delivery<br>Month Day Year   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                     |  |  |  |                           |  |   | 23e. Did tobacco use contribute to the cause of death?<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</i> |  |
|                                     |  |   |                                     |  |  |  |                           |  |   | 24a. Was an autopsy performed?<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>  |  |
|                                     |  |   |                                     |  |  |  |                           |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>  |  |
|                                     |  | 25. Was case referred to medical examiner?<br><i>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</i>  |                                     | 26. Place of Death (Check only one)<br>Hospital: <i>► Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</i><br>Other: <i>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</i>                             |  |  |                           |  |   |   |  |
|                                     |  | 27. Manner of Death<br><i>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</i>   |                                     | 28a. Date of injury (Month, Day, Year)<br><i>► 28b. Time of injury M</i>   |  | 28c. Injury at work?<br><i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>  |                           | 28d. Describe how injury occurred                                    |   |   |  |
|                                     |  |   |                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>► 28f. Location (Street and Number or Rural Route Number, City or Town, State)</i>  |  |  |                           |  |   |   |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br><i>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> |                                     | 29c. License number<br><i>1205135571</i>   |  |  |                           |  |   |   |  |
|                                     |  | 29b. Signature and title of certifier<br><i>►</i>   |                                     | 29d. Date signed (Month, Day, Year)<br><i>5/8/2012</i>   |  |  |                           |  |   |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Andrea M. Harriett 325 Greene St University of maryland medical center Baltimore, MD 21251</i>   |                                     |  |  |  |                           |  |   |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>   |                                     | 32. Registrar's Signature<br><i>Leanne J. Powell</i>   |  |  |                           |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

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State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend items 3 per doc, 17 per fh g927 5-24-12 vt  
 State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15019

1 - For  
State  
Registrar

|                                     |  |   |   |  |  |   |  |  |   |  |  |
|-------------------------------------|--|---|---|--|--|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Josephine Bradby</b>  |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>May 3, 2012</b>  | 3. Time of Death<br>P M<br><b>6:00 A M</b>   |  |   |  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>2020 Cliftwood Avenue</b>   |   |   | 4b. City, Town, or Location of Death<br><b>21213</b>   |  | 4c. County of Death<br><b>USA</b>   |  |  |   |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>217-26-3903</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 9, 1925</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |  |   |  |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
|                                     | 10e. Street and Number<br><b>2020 Cliftwood Avenue</b>   |   |   | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |  |  |   |  |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th grade</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic Engineer</b>  |  |  | 16b. Kind of Business/Industry<br><b>Private Homes</b>  |  |  |   |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Joseph Scott</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephus Scott Louvenia Diggs</b>  |  |   |  |  |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Bradby</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1528 Tunlaw Road Baltimore, MD 21218</b> |  |   |  |  |   |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cem.</b>  |  | Date<br><b>5/14/12</b>   | 20c. Location - City or Town, State<br><b>Owings Mills, Maryland</b>                                  |  |  |   |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Cullen Abbas</b>   |   | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206</b>   |  |  |   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   |   |  |  |   |  | Approximate Interval Between Onset and Death   |   |  |  |
|                                     | <p>a. Due to (or as a consequence of):<br/><b>COPD - Chronic Obstructive Pulmonary Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |  |  |   |  |  |   |  |  |
|                                     | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |   |  |  |
|                                     |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |  |   |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br><b>D72139</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 7<sup>th</sup> 2012</b>                                 |  |  |   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SYED Q. ABBAS 6701 N Charles Street Suite 4105 Baltimore MD 21204</b>   |   |   |  |  |   |  |  |   |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |   | 32. Registrar's Signature<br><b>Suzanne J. Parker</b>   |  |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tent.

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15020

1 - For  
State  
Registrar

|   |   |   |   |   |                          |   |   |
|---|---|---|---|---|--------------------------|---|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>    | 1. Decedent's Name (First, Middle, Last)<br><b>HERMAN STANLEY BAILEY</b>  |   |   |   |                          | 2. Date of Death<br>Month <b>MAY</b> Day <b>10</b> Year <b>2012</b>   | 3. Time of Death<br><b>10:01 A.M.</b>                       |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>   |   |   |   |                          | 4b. City, Town, or Location of Death<br><b>TIMONIUM</b>   | 4c. County of Death<br><b>BALTIMORE</b>                     |
| <b>Funeral<br/>Director</b>                   | 5. Social Security Number<br><b>219-18-7759</b>   | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/11/1926</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b>   | 10c. City, Town or Location<br><b>PARKVILLE</b>   | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>                        |                          |   |   |
|   | 10e. Street and Number<br><b>1872 EDGEWOOD ROAD</b>   | 10f. Zip Code<br><b>21234</b>   |   |   |                          | 10g. Citizen of What Country?<br><b>USA</b>   |   |
|   | 11. Marital Status<br><b>1 □ Never Married 2 X Married</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No</b><br>If Yes, Give Year or Dates.<br><b>WWII</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> | 14. Race - American Indian, Black, White, etc.<br><b>Specify: WHITE</b> |                          |   |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>5+ YEARS</b> | 16b. Kind of Business/Industry<br><b>CONTRACTS MANAGER</b>  | 16c. Kind of Business/Industry<br><b>WESTINGHOUSE</b>                   |                          |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>FRANK BAILEY</b>  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>STELLA UNAVAILABLE</b>  |   |   |                          |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>CLARA BAILEY/WIFE</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1872 EDGEWOOD ROAD PARKVILLE, MD 21234</b>                |   |   |                          |   |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>    | 20a. Method of Disposition<br><b>X Burial 2 □ Cremation 3 □ Removal from State</b><br>4 □ Donation 5 □ Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOLY ROSARY CEMETERY</b>   | Date<br><b>5/14/2012</b>  | 20c. Location - City or Town, State<br><b>DUNDALK, MD</b>               |                          |   |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>MO0217</b>  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.</b><br><b>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>                                    |   |   |                          |   |   |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>DEMENTIA</b>   |   |   |   |                          | Approximate Interval Between Onset and Death  |   |
|   | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____   |   |   |   |                          |   |   |
|   | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |                          |   |   |
|   | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy</b><br><b>4 □ Pregnant at time of death 5 □ Other (specify)</b><br><b>9 □ Unknown</b>  |   |   |   |                          | 23d. Date of delivery<br>Month Day Year   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                          | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>  |   |
|   |   |   |   |   |                          | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>   |   |
|   |   |   |   |   |                          | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>  |   |
|   | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |   |   |   |                          | 26. Place of Death (Check only one)<br>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 X Other (Specify)</b> <b>HOSPICE</b> |   |
|   | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation</b><br><b>2 □ Accident 6 □ Could not be determined</b><br><b>3 □ Suicide 4 □ Homicide</b>   |   |   |   |                          | 28a. Date of injury (Month, Day, Year)<br><b>M</b> 28b. Time of injury<br>M 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b> 28d. Describe how injury occurred                     |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
|   | 29a. Certifier<br>(Check only one)<br><b>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |   |   |                          | 29b. Signature and title of certifier<br><b>JUNECIA WHITE CRNP</b>  |   |
|   |   |   |   |   |                          | 29c. License number<br><b>R127474</b>   |   |
|   |   |   |   |   |                          | 29d. Date signed (Month, Day, Year)<br><b>5/10/12</b>   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |   |   |   |                          |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   |   |   |                          | 32. Registrar's Signature<br><b>JUNECIA WHITE</b>   |   |

MAY 10, 2012 10:01 a.m.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HERMAN BAILEY

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

The law requires that the death certificate be executed within 24 hours after death.

To the Physician or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

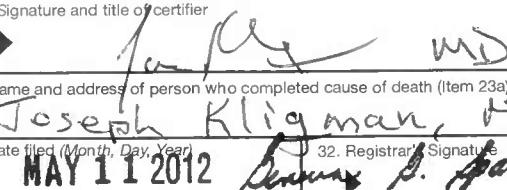
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15021

Reg. No.

1 - For  
State  
Registrar

|  |   |                                 |   |   |   |   |  |   |  |
|--|---|---------------------------------|---|---|---|---|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>OLIVER C. BAYNE, JR.</b>   |                                 |   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>9</b> , Year <b>2012</b>                                     | 3. Time of Death<br><b>7:05 A. M</b>                                    |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>8605 PLEASANT PLAINS ROAD</b>  |                                 |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |   |   | 4c. County of Death<br><b>BALTIMORE</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-40-0882</b>   |                                 | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>70</b><br>Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.             | 8. Date of Birth<br>(Month, Day, Year)<br><b>7/3/1941</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>             |  |
|  | Usual Residence of Decedent   |                                 |   |   |   |   |  |   |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b> | 10c. City, Town or Location<br><b>TOWSON</b>  |   |   |   |  | 10d. Inside City Limits<br>1 □ Yes 2 <b>X</b> No                        |  |
|  | 10e. Street and Number<br><b>8605 PLEASANT PLAINS ROAD</b>  |                                 |   | 10f. Zip Code<br><b>21286</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br>1 □ Never Married 2 <b>X</b> Married<br>3 □ Widowed 4 □ Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 □ Yes 2 <b>X</b> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 <b>X</b> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12TH GRADE</b>   |                                 |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>SHEET METAL WORKER</b>         |   |   | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>OLIVER C. BAYNE</b>   |                                 |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>IRENE QUINN</b>   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>OLIVER C. BAYNE/SON</b>  |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8605 PLEASANT PLAINS RD. TOWSON, MD 21286</b> |   |   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br>1 □ Burial 2 <b>X</b> Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORIAL, INC.</b>  |   |   | Date<br><b>5/10/2012</b>                        | 20c. Location - City or Town, State<br><b>CATONSVILLE, MD</b>  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |                                 | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.</b><br><b>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>                                    |   |   |   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                                 |   |   |   |   |  |   | Approximate Interval Between Onset and Death<br><b>ye - word</b> |
|  | <p>a. <b>Type 2 diabetes mellitus</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |                                 |   |   |   |   |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No 9 □ Unknown   |                                 | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |   |   | 23d. Date of delivery<br>Month Day Year         |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                 |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 <b>X</b> No 3 □ Probably 4 □ Unknown |   |  |
|  |   |                                 |   |   |   |   | 24a. Was an autopsy performed?<br>1 □ Yes 2 <b>X</b> No  |   |  |
|  |   |                                 |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 <b>X</b> No     |   |  |
|  | 25. Was case referred to medical examiner?<br>1 □ Yes 2 <b>X</b> No   |                                 | 26. Place of Death (Check only one)<br>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 <b>X</b> Residence 6 □ Other (Specify)     |   |   |   |  |   |  |
|  | 27. Manner of Death<br>1 <b>X</b> Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  |                                 | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of Injury<br>M  | 28c. Injury at work?<br>1 □ Yes 2 □ No  | 28d. Describe how injury occurred<br><b>N/A</b> |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                             |   |  |
|  | 29a. Certifier<br>1 <b>X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |   |   |   |   | 29c. License number<br><b>D 29601</b>  |   |  |
|  | 29b. Signature and title of certifier<br>  |                                 |   |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>5-10-12</b>  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Kligman, MD 416 E. Northland Ave, Baltimore, MD 21206</b>   |                                 |   |   |   |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |                                 |   | 32. Registrar's Signature<br><b>January S. Parker</b>   |   |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15022

1 - For  
State  
Registrar

|  |  |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|--|--|--|---|---|---|---|---|--|--|--|---|--|--------------------------|--|-----------------------------------|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Lynn D. Buck</b>  |  |   |   |   | 2. Date of Death<br>Month Day Year<br><b>May 2, 2012</b>      | 3. Time of Death<br>12:58 AM  |  |  |  |   |  |                          |  |                                   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Broadmead</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Cockeysville</b>   |   | 4c. County of Death<br><b>Baltimore</b>                       |   |  |  |  |   |  |                          |  |                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>496-14-8280</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov 15, 1921</b> | 9. Birthplace (State or Foreign Country)<br><b>Missouri</b>             |  |  |  |   |  |                          |  |                                   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  |   | 10b. County<br><b>Baltimore</b>   |   |   | 10c. City, Town or Location<br><b>Cockeysville</b>                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |                          |  |                                   |  |  |
|  | 10e. Street and Number<br><b>13801 York Road K-10</b>  |  |   | 10f. Zip Code<br><b>21030</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |  |   |  |                          |  |                                   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.       |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |  |   |  |                          |  |                                   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Seconday (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 5+ professor</b> |   | 16b. Kind of Business Industry<br><b>college</b>  |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Roy Lebeus Beck</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lora Ethel Crow</b>   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Hammon/daughter</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>386 Saddle Road Amboy, WA 98601</b> |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date  | 20c. Location - City or Town, State                                     |  |  |  |   |  |                          |  |                                   |  |  |
|  | 21. Signature <i>Ronald S. Wane, Director</i>  |  |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>                              |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b>   |  |   |   |   |   |   |  | Approximate Interval Between Onset and Death   |  |   |  |                          |  |                                   |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown  |  |   |   |   |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |                          |  |                                   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |                          |  |                                   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |                          |  |                                   |  |  |
|  | 27. Manner of Death<br><table border="1"><tr><td>1 <input type="checkbox"/> Natural</td><td>5 <input type="checkbox"/> Pending Investigation</td></tr><tr><td>2 <input type="checkbox"/> Accident</td><td>6 <input type="checkbox"/> Could not be determined</td></tr><tr><td>3 <input type="checkbox"/> Suicide</td><td></td></tr><tr><td>4 <input type="checkbox"/> Homicide</td><td></td></tr></table>  |  | 1 <input type="checkbox"/> Natural  | 5 <input type="checkbox"/> Pending Investigation  | 2 <input type="checkbox"/> Accident   | 6 <input type="checkbox"/> Could not be determined            | 3 <input type="checkbox"/> Suicide                                      |  | 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year) |  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |
| 1 <input type="checkbox"/> Natural                                 | 5 <input type="checkbox"/> Pending Investigation   |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
| 2 <input type="checkbox"/> Accident                                | 6 <input type="checkbox"/> Could not be determined   |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
| 3 <input type="checkbox"/> Suicide                                 |  |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
| 4 <input type="checkbox"/> Homicide                                |  |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |                          |  |                                   |  |  |
|  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
|  | 29b. Signature and title of certifier<br><i>Barbara Carroll, MD</i>  |  |   |   | 29c. License number<br><b>D38392</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>5/2/2012</b>   |  |  |   |  |                          |  |                                   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BARBARA CARROLL, MD, 13801 YORK RD., COCKEYSVILLE, MD 21030</b>   |  |   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><i>Susan J. Parker</i>   |   |   |   |   |  |  |  |   |  |                          |  |                                   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12. 58 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15023

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |   |  |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  |   | 3. Time of Death   |
| <b>Florence E. Bowers</b>   |  | Month Day Year<br><b>April 21, 2012</b>   |   | 6:20 AM M  |
| 4a. Facility Name (If not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |
| <b>Charlestown Retirement Center</b>  |  | <b>Catonsville</b>  |   | <b>Baltimore</b>   |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday)  | If Under 1 Year<br>Months Days Hours Min.  |
| <b>217-26-8994</b>  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | <b>99</b> Yrs.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug 18, 1912</b>  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug 18, 1912</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |
| Usual Residence of Decedent   |  | 10a. State  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   |  | <b>MD</b> <b>Baltimore</b>  |   | <b>Catonsville</b>   |
| 10e. Street and Number  |  | 10f. Zip Code   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| <b>709 Maiden Choice Lane #RGT225</b>   |  | <b>21228</b>  |   |  |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>0</b>  |   | 16b. Kind of Business Industry<br><b>fertilizer company</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>William Lewis Zaiser</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Augusta Foos</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Bowers/son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>828 Jack Street Baltimore, MD 21225</b>   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date   |
| 21. Signature of Funeral Service Director<br>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | <i>Cor pulmonale</i>  |   | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | <i>Chronic hypertension</i>   |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>DCR22290</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/12</b>  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DCR22290</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/12</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>✓ William S. Wade</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   | 32. Registrar's Signature<br><b>Laura J. Garske</b>  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15024

1- For State  
Registrar

|  |   |   |   |   |   |  |  |   |  |
|--|---|---|---|---|---|--|--|---|--|
| <b>Physician/<br/>Medical Examiner</b>     | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald W. Buchholz Jr.</b>   |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>8</b> Year <b>2012</b>                          | 3. Time of Death<br>1011 hrs   |  |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>800 Mountain Road</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Fallston</b>                                     |  | 4c. County of Death<br><b>Harford</b>  |   |  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>217-92-7702</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>46</b> Yrs.  | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth (MM/DD/YYYY)<br><b>May 30, 1965</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| <b>To Be Completed by Funeral Director</b> | 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Dundalk</b>  |   |   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  | 10e. Street and Number<br><b>917 Elton Avenue</b>   |   |   | 10f. Zip Code<br><b>21224</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b>  | College (1-4 or 5+) <b>2 years</b>  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Vice President</b>  |   |   | 16b. Kind of Business/Industry<br><b>I.U.O.E. Local 37</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ronald W. Buchholz Sr.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nancy Plumhoff</b>  |   |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald W. Buchholz Sr. Father</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 Ida Avenue, Essex, Maryland 21221</b> |   |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  | Date<br><b>May 14, 2012</b>   | 20c. Location - City or Town, State<br><b>Dundalk, Maryland</b>   |   |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Anthony G. Connelly</b>   |   |   | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk, P.A.<br/>7110 Sollers Point Road, Dundalk, MD. 21222</b>             |   |  |  |   |  |
| <b>Physician<br/>Medical<br/>Examiner</b>  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Multiple Injuries</b><br>Due to (or as a consequence of):   |   |   |   |   |  | Approximate Interval Between Onset and Death   |   |  |
|  | b. Due to (or as a consequence of):   |   |   |   |   |  |  |   |  |
|  | c. Due to (or as a consequence of):   |   |   |   |   |  |  |   |  |
|  | d. <input type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED #1 as noted, per me, g928 6-14-12 sm   |   |   |   |   |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month      Day      Year  |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  |   |   |   |   |   |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  |   |   |   |   |   |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA      Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene         |   |   |  |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>May 8, 2012</b>  | 28b. Time of Injury<br><b>1007 hrs</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Driver auto auto collision</b>   |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) <b>Major Road / Highway</b>   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>800 Mountain Road, Fallston, MD</b> |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | 29b. Signature and title of certifier<br><b>Donna M. Vincenti, MD</b>   |   | 29c. License number<br><b>O.C.M.E.</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b>  |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |   |   |   |   |  |  |   |  |
|  |   |   |   |   |   |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   | 32. Registrar's Signature<br><b>Donna J. Park</b>   |   |   |  |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15025

1 - For State Registrar

|  |  |  |   |  |  |  |                                       |   |  |  |                                       |
|--|--|--|---|--|--|--|---------------------------------------|---|--|--|---------------------------------------|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Glen Edward Burr</b>  |  |   |  |  |  |                                       | 2. Date of Death<br>Month Day Year<br><b>May 7 2012</b>                 | 3. Time of Death<br>140 PM                     |  |                                       |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LORIEN @ RIVERSIDE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BELCAMP</b> |  |  | 4c. County of Death<br><b>HARFORD</b> |   |  |  |                                       |
| Funeral Director   | 5. Social Security Number<br><b>504-24-5772</b>  |  | 6. Sex<br><b>X Male</b>   | 7. Age (In yrs. last birthday)<br><b>83 Yrs.</b>       | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 19, 1928</b>                       |                                       | 9. Birthplace (State or Foreign Country)<br><b>South Dakota</b>         |  |  |                                       |
|  | Usual Residence of Decedent  |  | 10a. State<br><b>Maryland</b>   |  |  | 10b. County<br><b>Harford</b>  |                                       |   | 10c. City, Town or Location<br><b>Aberdeen</b> |  | 10d. Inside City Limits<br><b>Yes</b> |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>430 Holiday Drive</b>   |  |   |  | 10f. Zip Code<br><b>21001</b>  |  |                                       | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |                                       |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1946-1966</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b></b>   |  |                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |                                       |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>1</b>  |  | 16b. Kind of Business/Industry<br><b>Military</b>  |  |                                       | 16c. Date of Death<br><b>U.S. Government</b>                            |  |  |                                       |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Burr</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeanette Canfield</b>  |  |                                       |   |  |  |                                       |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlotte Burr (wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>430 Holiday Drive, Aberdeen, Maryland 21001</b>  |  |                                       |   |  |  |                                       |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Kirchenbauer</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BelAir Memorial Gardens</b>  |  | Date<br><b>5/10/12</b>   |  |                                       | 20c. Location - City or Town, State<br><b>BelAir, Maryland</b>          |  |  |                                       |
|  | 21. Signature of Funeral Service Licensee<br><b>Kirchenbauer</b>   |  |   |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.</b>  |  |                                       |   |  |  |                                       |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |                                       |   |  | Approximate Interval Between Onset and Death |                                       |
|  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |                                       |   |  |  |                                       |
|  | 23e. Did tobacco use contribute to the cause of death?<br><b>Dementia, atrial fibrillation, coronary artery disease, Diabetes mellitus</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |                                       |   |  |  |                                       |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                       |   |  |  |                                       |
| Physician /Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |                                       |   |  |  |                                       |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day, Year)   |  | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred     |   |  |  |                                       |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                       |   |  |  |                                       |
|  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>C. M. M.</b>  |  |  |  |                                       |   |  |  |                                       |
|  | 29c. License number<br><b>D27975</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/12</b>  |  |  |  |                                       |   |  |  |                                       |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Arvin Michalewski 615 North St. #14 Bel Air, MD 21014</b>   |  |   |  |  |  |                                       |   |  |  |                                       |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Anna S. Park</b>  |  |  |  |                                       |   |  |  |                                       |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitpermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15026

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 2r is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit medical certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |  |   |   |
|---|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>2:50 P M  |
| CATHERINE RUBY BROCK  |  |  |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><i>Baltimore Washington Medical Center</i>  |  | 4b. City, Town, or Location of Death<br><i>Glen Burnie</i>   |   | 4c. County of Death<br><i>Anne Arundel</i>  |
| 5. Social Security Number<br><b>213 12 0657</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>91 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>09 06 1920  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | If Under 1 Year<br>Months Days Hours Min.  |   | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Pasadena</b>  |
| 10e. Street and Number<br><b>121 Appian Way</b>   |  | 10f. Zip Code<br><b>21122</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Officer</b>  |   | 16b. Kind of Business/Industry<br><b>National Security Agency</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Walton Mister</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Bosley</b>   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dawn Scott - Niece</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7777 Tick Neck Rd Pasadena, MD 21122</b>   |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Bayview Crematory</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>   |   | 20c. Date<br><b>5/10/12</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>GJ Goncè Funeral Home, PA<br/>169 Riviera Drive Pasadena, MD 21122</b>  |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>Cerebrovascular Accident</b><br><b>    {</b><br><b>a. Due to (or as a consequence of):</b><br><b>    {</b><br><b>    b. Due to (or as a consequence of):</b><br><b>    {</b><br><b>    c. Due to (or as a consequence of):</b><br><b>    {</b><br><b>    d. _____</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b><br><b>    {</b><br><b>    b. Due to (or as a consequence of):</b><br><b>    {</b><br><b>    c. Due to (or as a consequence of):</b><br><b>    {</b><br><b>    d. _____</b> |  |  |   |   |
| Approximate Interval Between Onset and Death  |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>28d. Describe how injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29c. License number<br><b>D 32744</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 11 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)<br><b>MARIA GAVIRIA MD 301 Hospital Dr Glen Burnie MD</b>   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br>   |   |   |

ORIGINAL

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15027

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |   |
|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Maurice R. Constant</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 15, 2012</b>  | 3. Time of Death<br><b>10:50 AM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>21 Brittany Lane</b>  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>  |   |
| 4c. County of Death<br><b>Worcester</b>  |  |  |   |
| 5. Social Security Number<br><b>007-34-6443</b>  |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>73 Yrs.</b>  |
| 8. If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |   |
| 9. Birthplace (State or Foreign Country)<br><b>Maine</b>   |  | 10. Inside City Limits<br><b>1 Yes 2 No</b>  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>  |   |
| 10c. City, Town or Location<br><b>Berlin</b>   |  | 10f. Zip Code<br><b>21811</b>  |   |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |
| 11. Marital Status<br><b>1 Never Married 2 Married</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates.<br><b>'55-58</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:<br><b>white</b> |
| 14. Race - American Indian, Black, White, etc.<br><b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>carpenter</b>  |  | 16b. Kind of Business/Industry<br><b>construction</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Donat Lionel Constant</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Rose Ouellette</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Constant/spouse</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21 Brittany Lane Berlin, MD 21811</b>                              |   |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date  |
| 4 Donation 5 Other (Specify)   |  | 20c. Location - City or Town, State  |   |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Severe Anemia</b>   |  | Approximate Interval Between Onset and Death   |   |
| b. Due to (or as a consequence of):<br><b>Advanced Myelodysplasia</b>  |  |  |   |
| c. Due to (or as a consequence of):  |  |  |   |
| d. _____   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy</b><br><b>4 Pregnant at time of death 5 Other (specify)</b><br><b>9 Unknown</b> |   |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |
|  |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |   |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>                   |   |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide</b>  |  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury</b>   | 28c. Injury at work?<br><b>1 Yes 2 No</b>   |
| 5 Pending Investigation<br>6 Could not be determined   |  | <b>M</b>   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>(Check only one)</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>00066198</b>   |   |
| 29b. Signature and title of certifier<br><b>Justinian Ngaiza</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/3/12</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Justinian Ngaiza 100 E. Carroll St. Salisbury, MD, 21801</b>  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Anna J. Parker</b>   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15028

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |  |  |   |
|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Carlos Cabral</b>  |  | 2. Date of Death<br>Month <b>May</b> Day <b>9</b> , Year <b>2012</b>   |  | 3. Time of Death<br><b>10:25p M</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>7715 Meath Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |
| 5. Social Security Number<br><b>212-48-2074</b>   |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b> | If Under 1 Year<br>Months<br><b>0</b><br>If Under 24 Hrs.<br>Days<br><b>0</b><br>Hours<br><b>0</b><br>Min.<br><b>0</b>  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>January 18, 1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10. Usual Residence of Decedent<br><b>Md. Baltimore</b>   |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Dundalk</b>   |
| 10e. Street and Number<br><b>7715 Meath Road</b>  |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.<br/><b>2 years</b></b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>Specify: White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>2 years</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |  | 16b. Kind of Business/Industry<br><b>Baltimore County School</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Manuel Cabral</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Concedeco</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maria Cabral Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7715 Meath Road, Dundalk, Md. 21222</b>  |  |   |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial</b>   |  | Date<br><b>May 12, 2012</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Anthony Connelly</b>  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Dundalk, P.A.<br/>7110 Sollers Point Road, Dundalk, Md. 21222</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>  |
| 23a. Part 1. Enter the disease, or complications that caused the death (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line).<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |  |  |  | Approximate Interval Between Death and Death<br><b>7 years</b>  |
| b. Due to (or as a consequence of):<br><b>Coronary artery disease</b>   |  |  |  |   |
| c. Due to (or as a consequence of):<br><b>Diabetes Mellitus</b>   |  |  |  |   |
| d.  |  |  |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b> |  | 23d. Date of delivery<br>Month Day Year   |
| 24. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>       |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |
| 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br><b>M</b>                  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |
|   |  | 28d. Describe how injury occurred  |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, MD 21222</b>  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D44793</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6730 46th BIRD AVE BALT MD 21222</b>   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Laura S. Jones</b>   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G927, 5/17/2012, WS

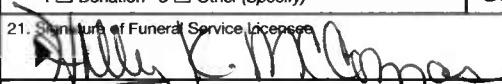
State of Maryland / Department of Health and Mental Hygiene

2012 15029

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |   |   |   |  |
|--|--|---|---|---|---|---|---|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LOVELLA COMPTON</b>   |   |   | 2. Date of Death<br>Month Day Year<br><b>MAY 9 2012 535PM</b>   |   |   | 3. Time of Death  |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Center @ GBMC</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>   |   |   | 4c. County of Death<br><b>Baltimore</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>228-46-4880</b>  |   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>74 Yrs.</b>  | If Under 1 Year<br>Months<br><b></b>  | If Under 24 Hrs.<br>Hours<br><b></b>          | 8. Date of Birth<br>(Month, Day, Year)<br><b>Mar. 9, 1938</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |
|  | Usual Residence of Decedent<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Abingdon</b>  |   |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>209 A Oak Leaf Circle</b>   |   |   |   | 10f. Zip Code<br><b>21009</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b> |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White</b> |   |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b>  |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>                  |   |   | 16b. Kind of Business/Industry<br><b>Housekeeper</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Giles Eli Compton</b>  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella Edna Street</b>  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Gardner / Daughter</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3011 Merle Court, New Windsor, Maryland 21776</b> |   |   |   |   |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Conowingo Cemetery</b>   |   | Date<br><b>5/14/2012</b>                      | 20c. Location - City or Town, State<br><b>Conowingo, Maryland</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>                               |   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Lung Cancer</b>  |  |   |   | Approximate Interval Between Onset and Death<br><b>1 YEAR</b>   |   |   |   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |   |   |   |   |   |  |
| a. Due to (or as a consequence of):<br><b>Metastatic Lung Cancer</b>   |  |   |   |   |   |   |   |   |  |
| b. Due to (or as a consequence of):<br><b></b>   |  |   |   |   |   |   |   |   |  |
| c. Due to (or as a consequence of):<br><b></b>   |  |   |   |   |   |   |   |   |  |
| d. <b></b>   |  |   |   |   |   |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>              |   |   |   | Date of delivery<br>Month Day Year<br><b></b> |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br/>HYPERTENSION</b>  |  |   |   |   |   |   | 23d. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |  |
|  |  |   |   |   |   |   | 23e. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |  |
|  |  |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |   |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE</b> |   |   |   |   |   |   |  |
| 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury (Month, Day, Year)<br><b></b>   |   | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   | 28d. Describe how injury occurred             |   |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>   |   |   |   |   |  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |   |   |   |   |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D4636C</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>May 9 2012</b>  |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Melinda A. Gardner NO 6701 North Charles Street Baltimore MD</b>  |  |   |   |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |   |   |   |   |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

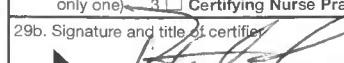
## Certificate of Death

2012 15030

1- For  
State  
Registrar

Reg. No.

Physician/  
Medical  
Examiner

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death  |   |   |  | 3. Time of Death  |   |
| ANNETTE L COHEN  |  | Month MAY Day 07, 2012 Year   |   |   |  | 5:00 PM   |   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   |   |  | 4c. County of Death   |   |
| DOVE HOUSE   |  | WESTMINSTER   |   |   |  | CARROLL   |   |
| 5. Social Security Number<br>213-20-8701   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>86 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>Month Day Year<br>01/19/1926  | 9. Birthplace (State or Foreign Country)<br>MD                      |
| Usual Residence of Decedent  |  | 10a. State<br>MD 10b. County<br>CARROLL 10c. City, Town or Location<br>SYKESVILLE   |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No        |   |
| 10e. Street and Number<br>1442 BUCKHORN ROAD   |  | 10f. Zip Code<br>21784  |   |   |  | 10g. Citizen of What Country?<br>USA  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br>WHITE |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) HOMEMAKER   |   | 16b. Kind of Business Industry<br>OWN HOME  |  |   |   |
| 17. Father's Name (First, Middle, Last)<br>SAMUEL  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>UNGER ESTHER LASOFF  |   |   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>BARRY COHEN/SON  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3930 YORK ROAD 1, MILLERS, MD 21102  |   |   |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ANSHE EMUNAH AITZ CHAIM CEMETERY  |   | Date<br>05/10/2012  | 20c. Location - City or Town, State<br>BALTIMORE, MD                                 |   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKEVILLE, MD 21208   |   |   |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Pancy Severeive Disease  |  |   |   |   |  |   |   |
| Approximate Interval Between Onset and Death<br>2 months   |  |   |   |   |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                       |   |   |  | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |   |  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) INPATIENT Hospital |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D20806   |   |   |  | 29d. Date signed (Month, Day, Year)<br>5/8/2012   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PATRICK TURNER MD 114 Business Center Dr Reisterstown MD 21131   |  |   |   |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>George J. Parker   |   |   |  |   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15031

1 - For  
State  
Registrar

|   |  |  |  |   |   |   |  |  |                                 |  |  |
|---|--|--|--|---|---|---|--|--|---------------------------------|--|--|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>CURTIS DUPREE</b>   |  |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>2</b> Year <b>2012</b> |  | 3. Time of Death<br><b>7 PM</b> |  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b> |   |  | 4c. County of Death<br><b>BALTIMORE</b>  |                                 |  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>216-74-5394</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>53</b><br>Yrs.         | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>  |  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>   |                                 | 8. Date of Birth<br>(Month Day Year)<br><b>8/15/1958</b>                                       |  |
|   |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |  |   |   |   |  |  |                                 |  |  |
| To Be Completed by Physician/Medical Examiner |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |  | 10e. Street and Number<br><b>5220 York Road</b>  |  | 10f. Zip Code<br><b>21212</b>   |   |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |                                 |  |  |
|   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Labourer</b>   |   | 16b. Kind of Business Industry<br><b>Jessup Produce</b>   |  |  |                                 |  |  |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>William Dupree</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Holmes</b>   |   |   |  |  |                                 |  |  |
|   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Lisa Dupree</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6008 St. Regis Rd. Baltimore, MD 21206</b>  |   |   |  |  |                                 |  |  |
|   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► Odyssey Gray</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>  |   | Date<br><b>5/8/2012</b>   |  | 20c. Location - City or Town, State<br><b>Dundalk, MD</b>  |                                 |  |  |
|   |  | 21. Signature of Funeral Service Licensee<br><b>► Odyssey Gray</b>   |  | 22. Name and Address of acq.<br><b>Joseph Kellum Funeral Home P.A.<br/>2222 N. North Ave. Baltimore, MD 21216</b>   |   |   |  |  |                                 |  |  |
|   |  | 23a. Part 1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>RENAL FAILURE</b>   |   |   |  | Approximate Interval Between Onset and Death   |                                 |  |  |
|   |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b.<br>c.<br>d.  |   |   |  |  |                                 |  |  |
|   |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |                                 |  |  |
|   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                 |  |  |
|   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)        |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 |  |  |
|   |  | 27. Manner of Death<br><b>1 Natural</b> <b>5 Pending Investigation</b><br><b>2 Accident</b> <b>6 Could not be determined</b><br><b>3 Suicide</b><br><b>4 Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 | 28d. Describe how injury occurred  |  |
|   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
|   |  | 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2 Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3 Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |                                 |  |  |
|   |  | 29b. Signature and title of certifier<br><b>► CLIFF FABER</b>  |  | 29c. License number<br><b>0 0024970</b>   |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>► MAY 2, 2012</b>  |                                 |  |  |
|   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CLIFF FABER 540 OLD COURT ROAD, RANDALLSTOWN, MARYLAND 21133</b>  |  |   |   |   |  |  |                                 |  |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 2. Registrar's Signature<br><b>Leanne S. Farber</b>   |   |   |  |  |                                 |  |  |

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

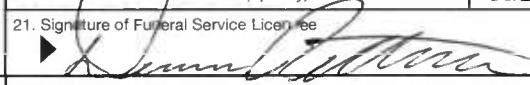
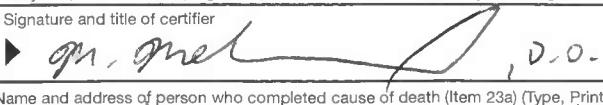
Certificate of Death

Reg. No.

2012 15032

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph O. Dito</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> Year <b>2012</b>  |  | 3. Time of Death<br>3:20 PM   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>051-14-9855</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   | If Under 1 Year<br>Months      Days      Hours      Min.  |  |
|   |  |   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 28, 1919</b>  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Gaithersburg</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>217 Booth Street Apt. 204</b>  |  | 10f. Zip Code<br><b>20878</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1943</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Longshoreman</b>   |  | 16b. Kind of Business Industry<br><b>Army</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Gelsomino Dito</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria G. Guadaquo</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph A. Dito (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 Phelps St., Gaithersburg, MD 20878</b>  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calvary Cemetery</b>   | Date<br><b>5/10/2012</b>   | 20c. Location - City or Town, State<br><b>Woodside, NY</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Metropolitan Funeral Service<br/>5517 Vine St., Alexandria, VA 22310</b>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br><br><b>a. endstage chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><br><b>b. pneumonia</b><br>Due to (or as a consequence of):<br><br><b>c. asbestosis</b><br>Due to (or as a consequence of):<br><br><b>d.</b>              |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypoxia, congestive heart failure, anemia<br/>chronic kidney disease</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |
|   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           | 28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>H72163</b>  |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/15/12</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mohammad Mehmood, DO 9901 Medical Center Drive, Rockville, Maryland 20850</b>  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br>  |  |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

JOSÉPH O DITO MAY 5, 2012 1520

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15033

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |                                       |                  |                     |                                   |
|--|---------------------------------------|------------------|---------------------|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month<br><b>4</b> | Day<br><b>29</b> | Year<br><b>2012</b> | 3. Time of Death<br><b>0550 M</b> |
|--|---------------------------------------|------------------|---------------------|-----------------------------------|

**Charles DeLoach**

|  |  |  |
|--|--|--|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death<br><b>Annapolis</b> | 4c. County of Death<br><b>Anne Arundel</b> |
|--|--|--|

**Anne Arundel Medical Center**

|   |                          |  |                           |                          |  |   |
|---|--------------------------|--|---------------------------|--------------------------|--|---|
| 5. Social Security Number<br><b>248-52-4312</b> | 6. Sex<br><b>XXM 2 F</b> | 7. Age (In yrs. last birthday)<br><b>72 Yrs.</b> | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/15/1935</b> | 9. Birthplace (State or Foreign Country)<br><b>Columbia, SC</b> |
|---|--------------------------|--|---------------------------|--------------------------|--|---|

Usual Residence of Decedent

|                         |                                    |   |   |
|-------------------------|------------------------------------|---|---|
| 10a. State<br><b>MD</b> | 10b. County<br><b>Anne Arundel</b> | 10c. City, Town or Location<br><b>Annapolis</b> | 10d. Inside City Limits<br><b>XX Yes 2 No</b> |
|-------------------------|------------------------------------|---|---|

10e. Street and Number

**931 Edgewood Rd Bld 931 #213**

10f. Zip Code

**21403**

10g. Citizen of What Country?

**USA**

|  |   |  |   |
|--|---|--|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1954-1957</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b></b> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |
|--|---|--|---|

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

**1**16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)**Industrial Engineer**

16b. Kind of Business/Industry

**Textile**

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>Charles Spurgeon DeLoach Sr.</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sara Blackwell</b> |
|--|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Keith DeLoach, son</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20897 Hamaca Ct Boca Raton, FL 33433</b> |
|---|--|

|   |   |                         |  |
|---|---|-------------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>► TSDHJM</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenlawn Mem Park</b> | Date<br><b>5/4/2012</b> | 20c. Location - City or Town, State<br><b>Columbia, SC</b> |
|---|---|-------------------------|--|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br><b>► TSDHJM</b> | 22. Name and Address of Facility<br><b>Harman Funeral Service, 7221 Grayburn Dr Ste G Glen Burnie MD 21061</b> |
|--|--|

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. Due to (or as a consequence of):<br><b>SEPSIS</b>   |  |
| b. Due to (or as a consequence of):<br><b>Bacteremia</b>   |  |
| c. Due to (or as a consequence of):  |  |
| d. _____   |  |

|            |   |   |   |
|------------|---|---|---|
| IF FEMALE: | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month<br>Day<br>Year |
|------------|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |

|   |   |  |
|---|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|---|--|

|  |  |                          |  |                                   |
|--|--|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury (Month, Day, Year) | 28b. Time of Injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|   |                                       |   |
|---|---------------------------------------|---|
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br><b>DM35494</b> | 29d. Date signed (Month, Day, Year)<br><b>4/29/2012</b> |
|---|---------------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Steven Research Anne Arundel Medical center</b> |
|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b> | 32. Registrar's Signature<br><b>George J. Jones</b> |
|---|---|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

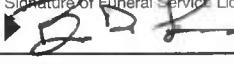
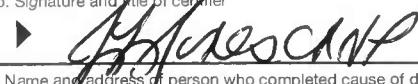
## Certificate of Death

Reg. No.

2012 15034

1- For State Registrar

Physician/  
Medical  
Examiner

|                                     |  |  |  |   |   |  |  |  |  |  |
|-------------------------------------|--|--|--|---|---|--|--|--|--|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY MAY DILLMANN</b>  |  |   |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>8</b> , Year <b>2012</b>       | 3. Time of Death<br><b>1:12P M</b>   |  |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>TIMONIUM</b>   |  | 4c. County of Death<br><b>BALTO.</b>                                       |  |  |  |
| Funeral Director                    |  | 5. Social Security Number<br><b>219-22-9011</b>  | 6. Sex<br><b>1 □ M 2 X F</b>   | 7. Age (in yrs. last birthday)<br><b>83</b><br>Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>12-11-1928</b>                | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |
| To Be Completed by Funeral Director |  | Usual Residence of Decedent<br><b>M.D.</b>   |  | 10a. State <b>MD.</b> 10b. County <b>BALTO.</b> 10c. City, Town or Location <b>TIMONIUM</b>   |   |  |  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>       |  |
|                                     |  | 10e. Street and Number<br><b>53 GREENMEADOW DRIVE</b>  |  |   | 10f. Zip Code<br><b>21093</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                |  |  |  |
|                                     |  | 11. Marital Status<br><b>1 □ Never Married 2 □ Married<br/>3 □ Widowed 4 X Divorced</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No<br/>If Yes, Give X Year or Dates.</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b><br>Specify: |  |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9TH</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   | 16b. Kind of Business/Industry<br><b>HOME</b>                                |  |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM LOOS</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>IRENE TURNER</b>  |  |  |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BRUCE SENFT</b> SON   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>53 GREENMEADOW DRIVE TIMONIUM, MD. 21093</b>  |  |  |  |  |  |
|                                     |  | 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>   |  | Date<br><b>5-11-2012</b>   | 20c. Location - City or Town, State<br><b>BALTO. MD.</b>   |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>MILLER-DIPPEL FUNERAL HOME, INC.</b><br><b>6415 BELAIR ROAD BALTO. MD. 21206</b>                           |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death   |
|                                     |  | <p>a. Due to (or as a consequence of):<br/><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |   |  |  |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 X No<br/>9 □ Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b>          |   | 23d. Date of delivery<br>Month      Day      Year                            |  |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b> |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 X Other (Specify)</b> <b>HOSPICE</b> |   | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 X No</b> |  |  |
|                                     |  | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide<br/>4 □ Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>                                | 28d. Describe how injury occurred  |  |  |  |
|                                     |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
|                                     |  | 29a. Certifier<br><b>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>R149792</b>   |   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/2012</b> |  |
|                                     |  | 29b. Signature and title of certifier<br>   |  |   |   |  |  |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |  |   |   |  |  |  |  |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |  |  |

MAY 8, 2012 1:12 p.m.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DOROTHY DILLMAN

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15035

**1- For State Registrar**

Reg. No.

**Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1615 hrs |
| David Lee Davis                          | April 23, 2012                     |                              |

**Funeral Director**

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 4a. Facility Name (if not institution, give street and number)<br>204B Maple Avenue | 4b. City, Town, or Location of Death<br>Glen Burnie                        | 4c. County of Death<br>Anne Arundel       |   |   |  |
| 5. Social Security Number<br>195-30-0583  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>71 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>07/22/1940 | 9. Birthplace (State or Foreign Country)<br>PA |

**To Be Completed by Funeral Director**

Usual Residence of Decedent  
10a. State MD Anne Arundel 10c. City, Town or Location Glen Burnie 10d. Inside City Limits 1  Yes 2  No

10e. Street and Number  
204B Maple Avenue 10f. Zip Code  
21061 10g. Citizen of What Country?  
USA

11. Marital Status  
1  Never Married 2  Married 12. Was Decedent Ever in U.S. Armed Forces?  
1  Yes 2  No  
3  Widowed 4  Divorced If Yes, Give Year  
1960-68 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify: White 14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (14 or 5+) Naval Communications Tech 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
16b. Kind of Business/Industry  
Federal Gov't

17. Father's Name (First, Middle, Last)  
Gilbert Claude Davis 18. Mother's Name (First, Middle, Maiden Surname)  
Dorothy Ashmore Tomlinson

19a. Informant's Name/Relationship (Type, Print)  
Eileen K Reed First Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
102 Windcrest Court Beaver Falls PA 15010

20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other Specify:  
Atlantic Crem 20b. Place of Disposition (Name of cemetery, crematory or other place)  
Date  
5/11/12 20c. Location - City or Town, State  
Glen Burnie MD

21. Signature of Funeral Service Licensee  
Thomas Allen PA 7090 Ridge Rd Hanover MD

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

**Medical Certification: To Be Completed by Physician/Medical Examiner****To Be Completed by Funeral Director**

|  |   |  |  |                                   |
|--|---|--|--|-----------------------------------|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   | a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.  | Approximate Interval Between Onset and Death   |  |                                   |
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, 27, per me, g927 5-29-12 sm   |   |  |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year  |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                                   |
|  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |
|  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene      |  |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>One) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223   |  |                                   |
| 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>April 24, 2012  |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a)   |   | 31. Date filed (Month, Day, Year)<br>MAY 11 2012 32. Registrar's Signature<br>Anna J. [Signature]  |  |                                   |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2012 1503b

|   |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
|---|--|--|--|--|---|---|--|--|--|--|--|--------------------------|--|-----------------------------------|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Anna Mae Dennler</b>  |  |  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>05/07/2012</b>  | 3. Time of Death<br>M<br><b>7:00 a</b>                       |  |  |                          |  |                                   |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>3724 Second Street</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   |  | 4c. County of Death  |  |  |  |                          |  |                                   |
| Funeral<br>Director   |  | 5. Social Security Number<br><b>199-20-8683</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b><br>Yrs.   | If Under 1 Year<br>Months Days Hours Min. | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>10/29/1927</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>        |  |  |                          |  |                                   |
|   |  | Usual Residence of Decedent<br><b>MD</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County                               |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                          |  |                                   |
| To Be Completed by Funeral Director   |  | 10e. Street and Number<br><b>3724 Second Street</b>  |  |  | 10f. Zip Code<br><b>21225</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |                          |  |                                   |
|   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>2 yrs</b>                                       |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                     |  |                          |  |                                   |
| To Be Completed by Funeral Director   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b>   |   |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>  |  |  |  |                          |  |                                   |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Leroy Grill</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katie Rudy</b>  |   |  |  |  |  |  |                          |  |                                   |
| To Be Completed by Physician/Medical Examiner   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dae L. Kidd Daughter</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1121 Odenton Road Odenton MD 21113</b>  |   |  |  |  |  |  |                          |  |                                   |
|   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Atlantic Crem</b>  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crem</b>  |   |  | Date<br><b>5/10/12</b>   | 20c. Location - City or Town, State<br><b>Glen Burnie MD</b> |  |  |                          |  |                                   |
| To Be Completed by Physician/Medical Examiner   |  | 21. Signature of Funeral Service Licensee<br><b>Thomas Allen</b>   |  |  | 22. Name and Address of Facility<br><b>Simplicity Crem &amp; Fun Serv Thomas AllenPA 7090 Ridge Rd Hanover MD</b>   |   |  |  |  |  |  |                          |  |                                   |
|   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Chronic Obstructive Pulmonary Disease</b> |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| 23a. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Throat Cancer</b>  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| IF FEMALE:  |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |                          |  |                                   |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                     |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  |  |  | 28a. Date of injury<br>(Month, Day, Year)                  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Anna Mae Dennler</b>   |  |  |   |   |  |  |  | 29c. License number<br><b>D51596</b>   | 29d. Date signed (Month, Day, Year)<br><b>May 9th 2012</b> |                          |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K. Ambalavanan 7845 Oakwood Road Glen Burnie MD 21061</b>  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>J. Parker</b>  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| Baltimore, Maryland 21215-0036  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| Division of Vital Records, P.O. Box 68760   |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| Physician/<br>Medical<br>Examiner   |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  |  |  |  |  |   |   |  |  |  |  |  |                          |  |                                   |

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, name 2 should be detached for use as the burial-trans-

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, **The Medical Examiner must be notified at once.**

Physician  
Medical  
Examiner

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans-

State  
Particulars

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15037

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |   |   |   |   |  |
|---|--|---|---|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Raymond Lee Eubank, Sr.</b>  |  |   | 2. Date of Death<br>Month<br><b>May</b>                     | Day<br><b>5</b> , 2012  | Year<br>16:50 AM                        | 3. Time of Death  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Seasons Hospice/ Northwest Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b> |   | 4c. County of Death<br><b>Baltimore</b> |   |  |
| 5. Social Security Number<br><b>214-62-6404</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>59 Yrs.</b>            | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours               | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 17, 1953</b>    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore City</b>  |   | 10c. City, Town or Location<br><b>1932 Parksley Ave.</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>1932 Parksley Ave.</b>   |  |   | 10f. Zip Code<br><b>21230</b>                               |   |   | 10g. Citizen of What Country?<br><b>United States</b>             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10th</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>N/A</b> |   | 16b. Kind of Business/Industry<br><b>Baker</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edwin Bryce Eubank</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Sowers</b>   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonnie Houck / Daughter</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2628 Wendover Road, Parkville, Maryland 21234</b>   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   | Date<br><b>May 9, 2012</b>              | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |
| 21. Signature of Funeral Service Licensee<br><i>Patricia Davis Blodget</i>  |  |   |   | 22. Name and Address of Facility<br><b>AMBROSE FUNERAL HOME, INC.</b><br><b>1328 Sulphur Spring Rd., Arbutus, Maryland 21227</b>  |   |   |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown          |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year                | Approximate Interval Between Onset and Death<br><b>Not long</b> |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA |  | Other:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Inpatient home</i>  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                      |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>100 N. University Rd. #600, Aviation Plaza, Suite N-12, Glen Burnie, MD 21061</b>  |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Robert W. McWhorter MD</i>   |  | 29c. License number<br><b>0045575</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5-6-2012</b> |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert W. McWhorter MD 6934 AVIATION PLAZA SUITE N-12 GLEN BURNIE, MD 21061</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><i>James J. Parker</i>   |  | ORIGINAL   |   |

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

51

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 19a per fh g927 5-11-12 vt  
 State of Maryland Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15038

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Almeter Finley</b>  |   |  |   | 2. Date of Death<br>Month <b>5</b> Day <b>9</b> Year <b>12</b> | 3. Time of Death<br><b>8:10 PM</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Joseph Richey Hospice</b>           |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-24-3823</b>  | 6. Sex<br><b>M</b>  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/25/1926</b>     | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                  |  |
|   | Usual Residence of Decedent<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><b>Yes</b>  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>  |   | 10f. Zip Code<br><b>21216</b>                                  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 10e. Street and Number<br><b>2703 Westwood Avenue</b>  |   |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   | 11. Marital Status<br><b>Widowed</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>No</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>No</b>                   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>                |  |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Beautician</b>              |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>         |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Charlie Patterson</b>                                      |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Willis Wright</b>   |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print) (Niece)<br><b>Mrs. Farverne Moore</b>                   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3714 Garand Rd Ellicott City, MD 21042</b> |   |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  | 20a. Method of Disposition<br><b>Burial</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |   | Date<br><b>5/11/2012</b>                                       | 20c. Location - City or Town, State<br><b>Woodlawn, MD</b>                   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Chayesey Gray</b>  |   | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home, P.A.<br/>2222 W. North Ave. Baltimore, MD 21216</b>                        |   |  |  |  |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)<br/><b>Pancreatic cancer</b></p> <p>Approximate Interval Between Onset and Death</p> <p>a. Due to (or as a consequence of):<br/><b>Pancreatic cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>No</b>  |  | 23c. If yes, outcome of pregnancy<br><b>Live Birth</b> <b>Fetal death</b> <b>Ectopic pregnancy</b><br><b>Pregnant at time of death</b> <b>Other (specify)</b><br><b>Unknown</b> |  |   |  | 23d. Date of delivery<br>Month <b>Day</b> <b>Year</b>                        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>No</b>          |  |
|   |  |   |  |   |  | 24a. Was an autopsy performed?<br><b>No</b>                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>No</b> |
| 25. Was case referred to medical examiner?<br><b>No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>Hospice</b><br>Other: <b>Other (Specify)</b>  |  |   |  |  |  |
| 27. Manner of Death<br><b>Natural</b><br><b>Accident</b><br><b>Suicide</b><br><b>Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>No</b>   | 28d. Describe how injury occurred                              |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier<br><b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>W.L.</b>  |  | 29c. License number<br><b>10064267</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5-9-12</b>                          |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr Karen L. Parsons Brown</b> <b>827 Linden Av Balt, MD 21201</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Barbara J. Parker</b>   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15039

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Catherine E. Franklin</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>May 10, 2012</b>  | 3. Time of Death<br>1:00 A M                                 |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Sun Valley Nursing Home</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  |  |
| 4c. County of Death<br><b>Carroll</b>   |  | 4d. Social Security Number<br><b>219-14-8455</b>  |   |  |  |  |
| 5. Social Security Number<br><b>219-14-8455</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>88 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Hours Min.                               |  |
| 8. Date of Birth (Month, Day, Year)<br><b>9/14/1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>Westminster</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>2955 Ridge Rd.</b>   |  |   |   | 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>                    |  |  | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Henry C. Reaver</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Smith</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet Billings/Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1154 Bloom Rd., Westminster, MD 21157</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Linganore Cemetery</b>   |   | Date<br><b>5/14/2012</b>   | 20c. Location - City or Town, State<br><b>Unionville, MD</b> |  |
| 21. Signature of Funeral Service License<br><b>Jamie B. Cawley</b>  |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Home &amp; Crematory, P.A.<br/>1212 W. Old Liberty Rd., Winfield, MD 21784</b>       |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Liver Cancer</b><br>Approximate Interval Between Onset and Death<br><b>Month</b>   |  |   |   |  |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last<br><b>{</b>  |  |   |   |  |  |  |
| 23c. If female:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  |   |   |  |  |  |
| 28a. Date of injury (Month, Day, Year)<br><b>M</b> 28b. Time of injury<br>28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |
| 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Jeff P. Henderson</b>   |  |   |   |  |  |  |
| 29c. License number<br><b>00051924</b>  |  |   |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>  |  |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jefferson P. Henderson, 310 2973 Manchester Rd Manchester, MD</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>James P. Jones</b>  |   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15040

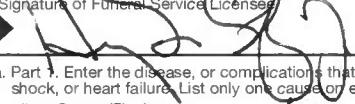
1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|   |                                    |   |  |  |   |   |  |  |
|---|------------------------------------|---|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Spurgeon S. Foster</b>   |                                    |   |  |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>05</b> Year <b>2012</b>                            | 3. Time of Death<br><b>07:25 PM</b>                              |
| 4a. Facility Name (if not institution, give street and number)<br><b>717 213th Street</b>   |                                    |   |  | 4b. City, Town, or Location of Death<br><b>Pasadena</b>  |   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>237-32-7344</b>   |                                    | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 30 1926</b> | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |  |
| Usual Residence of Decedent   |                                    |   |  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b> | 10c. City, Town or Location<br><b>Pasadena</b>  |  |  |   |   |  |  |
| 10e. Street and Number<br><b>717 213th Street</b>   |                                    |   |  | 10f. Zip Code<br><b>21122</b>  |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b>  |                                    |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HVAC Tech/Installer</b>   |   |   | 16b. Kind of Business/Industry<br><b>US Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Sheperd Foster</b>  |                                    |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie May Livengood</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane Foster</b> (spouse)   |                                    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>717 213th Street, Pasadena, MD 21122</b> |   |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                    |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Cemetery</b>  |   |   | <b>May</b> Date <b>11</b><br><b>2012</b>   | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br>   |                                    |   |  | 22. Name and Address of Facility<br><b>Stallings Funeral Home, P.A.</b><br><b>3111 Mountain Road, Pasadena, MD 21122</b>                     |   |   |  |  |

Medical Certificate: To Be Completed by Physician/Medical Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |                          |  |   |  |  |   |
|--|--|--|--------------------------|--|---|--|--|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Lung Disease</b><br><b>Coronary Artery Disease</b> |                          |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |                          |  | Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |                          |  | 29c. License number<br><b>D 50470</b>   |  |  |   |
| 29d. Date signed (Month, Day, Year)<br><b>5/7/2012</b>   |  |  |                          |  |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sridhar Atmar 7310 Ritchie Highway, #800 ; Glen Burnie MD 21061</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |                          |  | 32. Registrar's Signature<br>  |  |  |   |

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #31 State of Maryland 6/1/2012 Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15041

1 - For  
State  
Registrar

|  |  |  |   |   |   |   |  |   |  |  |
|--|--|--|---|---|---|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Anna Fones</b>  |  |   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Year <b>4, 2012</b>   | 3. Time of Death<br><b>4:30A M</b>              |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>   |  |   |   |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  | 4c. County of Death<br><b>BALTIMORE</b>         |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-56-6374</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb 21, 1934</b> | 9. Birthplace (State or Foreign Country)<br><b>Italy</b>   |   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  |   |   |   |   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Baltimore</b> | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>212 Eggburth Road #101</b>  |  |   |   |   |   | 10f. Zip Code<br><b>21206</b>  | 10g. Citizen of What Country?<br><b>USA</b>     |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>white</b> |   |  | 14. Race - American Indian, Black, White, etc.  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>nursing aide</b> |   |   | 16b. Kind of Business/Industry<br><b>healthcare</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ernesto Fones</b>  |  |   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carmella Cuomo</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elena Trois/sister in law</b>   |  |   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>617 Lavenham Court Lutherville, MD 21093</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date  | 20c. Location - City or Town, State  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |   |   |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>GANGRENOUS BOWEL</b>              |  |   |   |   |   |  |   | Approximate Interval Between Onset and Death<br><b>1 DAY</b>                                   |  |
|  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____  |  |   |   |   |   |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown   |   |   |   |  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |  |  |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |  |  |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                             |  |   |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Nurse Practitioner  |  | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D52096</b>  |   |   |   |  |   | 29d. Date signed (Month/Day/Year)<br><b>5/8/12</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID UTZSCHNEIDER, M.D. 7601 OSLER DRIVE TOWSON, MD 21204</b>  |  |   |   |   |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>5/8/12</b>   |  | 32. Registrar's Signature<br>   |   |   |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #9 per ANA RD C927 5/24/2012 JH  
 State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15042

|                                     |  |   |  |  |  |  |  |  |  |   |  |
|-------------------------------------|--|---|--|--|--|--|--|--|--|---|--|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>LINDA FERRARO</b>  |  |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>5</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>10:30 PM</b>  |  |   |  |
| Funeral<br>Director                 |  | 4a. Facility Name, (if not institution, give street and number)<br><b>Talbot Hospice 586 CYNWOOD PR.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |  | 4c. County of Death<br><b>Talbot</b>   |  |   |  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br><b>40-36-1144</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  |  | 7. Age (In yrs. last birthday)<br><b>66 Yrs.</b>   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>2/20/1946</b>   |  |   |  |
|                                     |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Bel Air</b>  |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>        |  |   |  |
|                                     |  | 10e. Street and Number<br><b>417 Greer Road</b>   |  |  |  | 10f. Zip Code<br><b>21015</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
|                                     |  | 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: white</b>  |  |   |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 5+</b>  |  | 16b. Kind of Business Industry<br><b>veterinarian</b>  |  | 16c. Kind of Business Industry<br><b>animal medicine</b>   |  |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Thomas John Ferraro</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris Virginia Pfluger</b>   |  |  |  |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ginnie Franks/sister</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 Greer Road Bel Air, MD 21015</b>   |  |  |  |  |  |   |  |
|                                     |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date   |  | 20c. Location - City or Town, State  |  |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>   |  |  |  |  |  |   |  |
|                                     |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>4 YEARS</b>  |  |
|                                     |  | <p>a. Due to (or as a consequence of):<br/><b>MULTIPLE MYELOMA</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |  |  |  |  |  |  |   |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>   |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br><b>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br/>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)</b> |  |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |
|                                     |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at work?<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of Injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                      |  | 28d. Describe how injury occurred   |  |
|                                     |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |  |  |  |  |   |  |
|                                     |  | 29b. Signature and title of certifier<br><b>DAVID H. SMITH, MD</b>  |  | 29c. License number<br><b>D39887</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/1/2012</b>   |  |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID H. SMITH, MD 8221 TEAL DRIVE, EASTON, MD 21601</b>   |  |  |  |  |  |  |  |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne S. Park</b>   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, per PHYS, G928, 6/5/2012, WS

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

## Certificate of Death

Reg. No. 2012 15043

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|                                   |  |  |  |   |  |   |  |   |  |  |  |
|-----------------------------------|--|--|--|---|--|---|--|---|--|--|--|
|                                   |  | 1. Decedent's Name (First, Middle, Last)   |  |   | 2. Date of Death   |   | 3. Time of Death   |   |  |  |  |
|                                   |  | <b>CLARENCE C. FARLOW</b>  |  |   | Month Day Year   |   | 9227 M   |   |  |  |  |
| Physician/<br>Medical<br>Examiner |  | 4a. Facility Name (if not institution, give street and number)   |  |   | 4b. City, Town, or Location of Death   |   |  | 4c. County of Death   |  |  |  |
| Funeral<br>Director               |  | 3517 Wilkens Ave.  |  |   | Baltimore City   |   |  |   |  |  |  |
|                                   |  | 5. Social Security Number  |  | 6. Sex  | 7. Age (In yrs. last birthday)   |   |  |   |  |  |  |
|                                   |  | 213-36-1731  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 73 Yrs.  |   | If Under 1 Year<br>Months Days Hours Min.  |   |  |  |  |
|                                   |  | Usual Residence of Decedent  |  |   | 10c. City, Town or Location  |   |  | 8. Date of Birth<br>(Month, Day, Year)  |  |  |  |
|                                   |  | Maryland   |  |   | Baltimore City   |   |  | May 2, 1939   |  |  |  |
|                                   |  | 10a. State   |  |   | 10b. County  |   |  | 9. Birthplace (State or Foreign Country)  |  |  |  |
|                                   |  | Maryland   |  |   |  |   |  | Maryland  |  |  |  |
|                                   |  | 10e. Street and Number   |  |   | 10f. Zip Code  |   | 10g. Citizen of What Country?  |   |  |  |  |
|                                   |  | 3517 Wilkens Ave.  |  |   | 21229  |   | United States  |   |  |  |  |
|                                   |  | 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
|                                   |  | 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |  | 16b. Kind of Business/Industry  |  |   |  |  |  |
|                                   |  | Elementary/Secondary (0-12)  |  | College (1-4 or 5+)   |  | Off Set Printer   |  | Printing  |  |  |  |
|                                   |  | 17. Father's Name (First, Middle, Last)  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)  |   |  |   |  |  |  |
|                                   |  | William Farlow   |  |   | Mary Josephine Biershing   |   |  |   |  |  |  |
|                                   |  | 19a. Informant's Name/Relationship (Type, Print)   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |   |  |   |  |  |  |
|                                   |  | Elaine L. Farlow / Wife  |  |   | 3517 Wilkens Ave., Baltimore, Maryland 21229   |   |  |   |  |  |  |
|                                   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |   | Date   | 20c. Location - City or Town, State   |  |  |  |
|                                   |  |  |  |   | Gardens Of Faith   |   | May 11, 2012   | Rosedale, Maryland  |  |  |  |
|                                   |  | 21. Signature of Funeral Service Licensee  |  |   | 22. Name and Address of Facility   |   |  |   |  |  |  |
|                                   |  | <i>Patricia Ann Blattner</i>   |  |   | AMBROSE FUNERAL HOME, INC.   |   |  |   |  |  |  |
|                                   |  |  |  |   | 1328 Sulphur Spring Rd., Arbutus, Maryland 21227   |   |  |   |  |  |  |
| Physician<br>Medical<br>Examiner  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   | Pancreatic Disease   |   |  | Approximate Interval Between Onset and Death  |  |  |  |
|                                   |  | Immediate Cause (Final disease or condition resulting in death)  |  |   | <i>Emphysema</i>   |   |  |   |  |  |  |
|                                   |  | { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   | a. Due to (or as a consequence of):  |   |  |   |  |  |  |
|                                   |  |  |  |   |  |   |  | b. Due to (or as a consequence of):   |  |  |  |
|                                   |  |  |  |   |  |   |  | c. Due to (or as a consequence of):   |  |  |  |
|                                   |  |  |  |   |  |   |  | d. Due to (or as a consequence of):   |  |  |  |
|                                   |  | IF FEMALE:   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |   | Date of delivery<br>Month Day Year   |   |  |  |  |
|                                   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |  |  |
|                                   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |   |  |  |  |
|                                   |  |  |  |   |  |   |  |   |  |  |  |
|                                   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
|                                   |  |  |  |   |  |   |  |   |  |  |  |
|                                   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)  |   |  |   |  |  |  |
|                                   |  |  |  |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |
|                                   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury   | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |  |
|                                   |  |  |  |   |  |   |  |   |  |  |  |
|                                   |  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
|                                   |  |  |  |   |  |   |  |   |  |  |  |
|                                   |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number  |   |  | 29d. Date signed (Month, Day, Year)   |  |  |  |
|                                   |  |  |  |   | <i>015872</i>  |   |  | <i>May 8, 2012</i>  |  |  |  |
|                                   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |  |   |  |   |  |  |  |
|                                   |  | <i>Howard Bier Bier 6934 Division Blvd Glen Burnie MD 21061</i>  |  |   |  |   |  |   |  |  |  |
|                                   |  | 31. Date filed (Month, Day, Year)  |  |   | 32. Registrar's Signature  |   |  |   |  |  |  |
|                                   |  | <i>MAY 11 2012</i>   |  |   | <i>Patricia A. Blattner</i>  |   |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15044

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Fitch, Catherine J.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |  |   |   |   |                                     |  |   |   |   |  |
|--|--|---|---|---|-------------------------------------|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE J. FITCH</b>  |  |   | 2. Date of Death<br>Month <b>05</b> Day <b>08</b> Year <b>2012</b>  |   |                                     | 3. Time of Death<br><b>5:20A M</b>   |   |   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>FRANKLIN Square HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |   |                                     | 4c. County of Death<br><b>Baltimore</b>  |   |   |   |  |
| 5. Social Security Number<br><b>219-60-7894</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (in yrs. last birthday)<br><b>94</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>12-13-1917</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   |  |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>BALTO.</b>  |   | 10c. City, Town or Location<br><b>MIDDLE RIVER</b>  |                                     |  |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |  |
| 10e. Street and Number<br><b>3 ALTIMETER COURT</b>   |  |   |   | 10f. Zip Code<br><b>21220</b>   |                                     |  | 10g. Citizen of What Country?<br><b>USA</b> |   |   |  |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b> |   |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |   | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6TH</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                          |   |                                     | 16b. Kind of Business/Industry<br><b>HOME</b>  |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL HOBLIK</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AGATHA NEVRLA</b>   |                                     |  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RONALD FITCH SON</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4030 KLAUSMIER ROAD NOTTINGHAM, MD. 21236</b>   |                                     |  |   |   |   |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>                              |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOLLY HILL</b>   |                                     |  | Date<br><b>5-12-2012</b>                    | 20c. Location - City or Town, State<br><b>MIDDLE RIVER, MD.</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Bruce Green</b>  |  |   |   | 22. Name and Address of Facility<br><b>SCHIMANEK FUNERAL HOME, INC 9705 BELAIR ROAD NOTTINGHAM, MD. 21236</b>   |                                     |  |   |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) |  |   |   | 23b. Due to (or as a consequence of):<br><b>FATAL Arrhythmia</b>  |                                     |  |   |   | Approximate Interval Between Onset and Death<br><b>hours</b>  |  |
|  |  |   |   | 23c. Due to (or as a consequence of):<br><b>Atherosclerotic CARDIOVASCULAR Disease</b>  |                                     |  |   |   | <b>Years</b>  |  |
|  |  |   |   | 23d. Due to (or as a consequence of):<br><b>Hypertension</b>  |                                     |  |   |   | <b>Years</b>  |  |
| 23e. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  |   |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>   |                                     |  |   |   | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |                                     |  |   |   |   |  |
|  |  |   |   | 23f. 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |                                     |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |                                     |  |   |   |   |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  |   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br><b>M</b>     | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred           |   |   |  |
|  |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                     |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)</b>   |  |   |   | 29c. License number<br><b>DO061662</b>  |                                     |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>05/08/2012</b>  |  |
| 29a. Certifier<br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)</b>                                   |  |   |   |   |                                     |  |   |   |   |  |
| 29a. Certifier<br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)</b>   |  |   |   |   |                                     |  |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) Type, Print)<br><b>HANSEN, JONATHAN L. 9000 FRANKLIN Square DR. Baltimore, MD 21237</b>   |  |   |   |   |                                     |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |   |   | 32. Registrar's Signature<br><b>Seneca P. Farrel</b>  |                                     |  |   |   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15045

1 - For  
State  
Registrar

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical  
Examiner****Funeral  
Director****To Be Completed by Funeral Director****Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician/  
Medical  
Examiner****Medical Certificate: To Be Completed by Physician/Medical Examiner****State  
Registrar**

|  |  |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
|--|--|---|---|---|--|--|--|----|--|---|----|--|--|----|--|--|----|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | Elizabeth Glaser  |   |   |  | 2. Date of Death<br>Month <input checked="" type="checkbox"/> May Day <input checked="" type="checkbox"/> 9 Year <input type="checkbox"/> 2012   | 3. Time of Death<br><input type="checkbox"/> 5:45 AM   |    |  |   |    |  |  |    |  |  |    |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | Roland Park Place Healthcare Center   |   |   |  | 4b. City, Town, or Location of Death<br>Baltimore City   |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 5. Social Security Number<br>213-09-9538   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>95 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br>Feb 4, 1917  | 9. Birthplace (State or Foreign Country)<br>Maryland   |    |  |   |    |  |  |    |  |  |    |  |  |
| Usual Residence of Decedent<br>Maryland  |  | 10c. City, Town or Location<br>Baltimore  |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 10e. Street and Number<br>830 West 40th Street   |  | 10f. Zip Code<br>21211  |   |   |  | 10g. Citizen of What Country?<br>USA   |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: USA   |    |  |   |    |  |  |    |  |  |    |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>2  |   | 16b. Kind of Business/Industry<br>Homemaker   |  |  | Own Residence  |    |  |   |    |  |  |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>James Edward Kane   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Alice Russell  |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>H. Donald Glaser (Son)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>709 Anglers Bend Way, Missoula, MT 59802   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |  | Date<br>5/11/2012  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |    |  |   |    |  |  |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>► Martin D. Lawson  |  |   |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road, Baltimore, Maryland 21212  |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| <table border="0"> <tr> <td>a.</td> <td>Advanced arteriosclerotic cardiovascular disease</td> <td>Approximate Interval Between Onset and Death<br/>Years</td> </tr> <tr> <td>b.</td> <td colspan="2">Due to (or as a consequence of): _____</td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of): _____</td> </tr> <tr> <td>d.</td> <td colspan="2">Due to (or as a consequence of): _____</td> </tr> </table>  |  |   |   |   |  |  |  | a. | Advanced arteriosclerotic cardiovascular disease | Approximate Interval Between Onset and Death<br>Years | b. | Due to (or as a consequence of): _____ |  | c. | Due to (or as a consequence of): _____ |  | d. | Due to (or as a consequence of): _____ |  |
| a.   | Advanced arteriosclerotic cardiovascular disease | Approximate Interval Between Onset and Death<br>Years   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| b.   | Due to (or as a consequence of): _____           |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| c.   | Due to (or as a consequence of): _____           |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| d.   | Due to (or as a consequence of): _____           |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |    |  |   |    |  |  |    |  |  |    |  |  |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |    |  |   |    |  |  |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 29b. Signature and title of certifier<br>► DR Isabelle Mac Gregor MD   |  | 29c. License number<br>D13657   |   |   |  | 29d. Date signed (Month, Day, Year)<br>May 9, 2012   |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR ISABELLE MAC GREGOR, 700 W 40TH STREET, BALTIMORE, MD 21211   |  |   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>Leanne A. Parker   |   |   |  |  |  |    |  |   |    |  |  |    |  |  |    |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15046

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>12:35 PM   |
| Selma Guion   |  | 05 04 2012  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br>Genesis- Randallstown   |  | 4b. City, Town, or Location of Death<br>Randallstown  |   | 4c. County of Death<br>Baltimore   |
| 5. Social Security Number<br>227-32-0164  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>Mar 9, 1927  |
| Usual Residence of Decedent   |  | 10a. State<br>MD 10b. County<br>Baltimore 10c. City, Town or Location<br>Randallstown 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 10e. Street and Number<br>9109 Liberty Road   |  | 10f. Zip Code<br>21133  |   | 10g. Citizen of What Country?<br>USA   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:       |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) unk   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) unk   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: black   |
| 17. Father's Name (First, Middle, Last)   |  | unk   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>unk   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Genesis Randallstown  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9109 Liberty Road Randallstown, MD 21133   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | 20c. Location - City or Town, State<br>Date  |
| 21. Signature of Funeral Service Licensee<br>Romaris S. Wade, Director  |  | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br>Alzheimer disease   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | a. Due to (or as a consequence of):   |   |  |
|   |  | b. Due to (or as a consequence of):   |   |  |
|   |  | c. Due to (or as a consequence of):   |   |  |
|   |  | d. Due to (or as a consequence of):   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)           |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. Location (Street and Number or Rural Route Number, City or Town, State)<br>9109 Liberty Rd Randallstown, MD 21133  |   |  |
| 29b. Signature and title of certifier<br>Sherla Farrell-Searey CRN #158889  |  | 29c. License number   |   | 29d. Date signed (Month, Day, Year)<br>5/4/2012  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>9109 Liberty Rd Randallstown, MD 21133  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012  |  | 32. Registrar's Signature<br>Sherla P. Farrel   |   |  |

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State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15047

**1 - For  
State  
Registrar**

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

**To Be Completed by Funeral Director**

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760**

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

|  |  |  |   |   |
|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Jean Grierson</b>   |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>8</b> Year <b>12/2/39</b> M   | 3. Time of Death<br><b>12:22:39 PM</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Hebrew Home of Greater Washington</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |   |
| 5. Social Security Number<br><b>093-24-1334</b>  |  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.   |
|  |  |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.   |
|  |  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Apr. 10, 1933</b>  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |
| 10a. State<br><b>VA</b>  |  |  | 10b. County<br><b>Prince William</b>  |   |
| 10c. City, Town or Location<br><b>Manassas</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>9847 Alan Court</b>   |  |  | 10f. Zip Code<br><b>20109</b>   |   |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>2</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrator</b>   |   | 16b. Kind of Business Industry<br><b>IBM</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>William Hatzmann</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Curtis</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William B. Grierson - Son</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9847 Alan Court, Manassas, VA 20109</b> |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Gate of Heaven</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  | Date<br><b>05-12-2012</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Julen Blendon</b>  |  |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |  |  | Approximate Interval Between Onset and Death  |   |
| a. Due to (or as a consequence of):<br><b>Dementia</b>   |  |  |   |   |
| b. Due to (or as a consequence of):  |  |  |   |   |
| c. Due to (or as a consequence of):  |  |  |   |   |
| d. Due to (or as a consequence of):  |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown                        |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)<br><b>Nursing Home</b> |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |
|  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>DOB64871</b>   |   |   |
| 29b. Signature and title of certifier<br><b>Mina Fazli</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5-8-2012</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mina Fazli, MD 6121 Montrose Rd Rockville MD 20852</b>  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Leanne J. Fazli</b>  |   |   |

**State  
Registrar**

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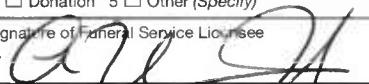
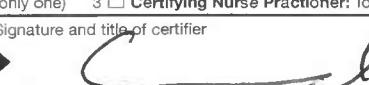
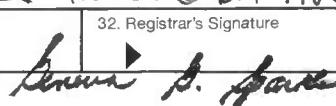
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15048

1 - For  
State  
Registrar

|                                     |  |  |   |                           |   |  |   |  |  |  |
|-------------------------------------|--|--|---|---------------------------|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Harvey Stephen Gartrell, Sr.</b>  |  |   |                           |   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>07</b> Year <b>2012</b>                            | 3. Time of Death<br><b>8:49 PM</b>   |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>St Agnes Hospital</b>   |  |   |                           | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  |   | 4c. County of Death  |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>215-34-0995</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b><br>Yrs.   | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 18, 1937</b>                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |  |
|                                     | 10a. State <b>MD</b>   |  |   |                           | 10b. County <b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br><b>622 Charraway Road</b>  |  |   |                           | 10f. Zip Code<br><b>21229</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:             |  |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b><br>Specify:                     |  |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Seconday (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Truck Driver</b>   |                           | 16b. Kind of Business Industry<br><b>U.P.S.</b>   |  |   |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Aaron Gartrell</b>   |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rachel Sensibaugh</b>   |  |   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia J. Gartrell-Daughter</b>   |  |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2412 Zion Road; Baltimore, MD 21227</b>             |  |   |  |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Mem. Park</b>  |                           | Date<br><b>5/11/2012</b>  | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>                     |   |  |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  |   |                           | 22. Name and Address of Facility<br><b>Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228</b> |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Severe Cardiomyopathy</b>   |  |   |                           |   |  |   |  | Approximate Interval Between Onset and Death<br><b>4 days</b>  |  |
|                                     | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |                           |   |  |   |  |  |  |
|                                     | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |                           |   |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                           |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                     |  |  |   |                           |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                           |   |  |   |  |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |                           | 28b. Time of Injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                           |  |  |  |
|                                     |  |  |   |                           |   |  |   |  |  |  |
|                                     |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                           |   |  |   |  |  |  |
|                                     | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>P26748</b>  |                           | 29d. Date signed (Month, Day, Year)<br><b>05/07/2012</b>  |  |   |  |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sameer Ahmed 900 S. Caton Ave Baltimore, MD 21229</b>   |  |   |                           |   |  |   |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |                           |   |  |   |  |  |  |

Gartrell, Harvey  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

15 x ✓

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15049

Reg. No.

1- For  
State  
Registrar

|  |  |  |  |                           |   |   |   |   |  |  |
|--|--|--|--|---------------------------|---|---|---|---|--|--|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEROY GOODWIN</b>   |  |  |                           |   |   |   | 2. Date of Death<br>Month<br><b>04</b> Day<br><b>29</b> Year<br><b>2012</b> | 3. Time of Death<br><b>07:45 AM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secours Hospital</b>  |  |  |                           | 4b. City, Town, or Location of Death<br><b>Baltimore MD</b>   |   |   | 4c. County of Death<br><b>Baltimore</b>                                     |  |  |
| Funeral Director   | 5. Social Security Number<br><b>121-40-3940</b>  | 6. Sex<br><b>M</b> 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs. | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>05/12/1950</b> | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |   |  |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Washington</b> 10c. City, Town or Location<br><b>Hagerstown</b>   |  |  |                           |   |   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>UNK</b>   |  |  |                           | 10f. Zip Code<br><b>21740</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>                                 |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>12 yrs</b> |  |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>     |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |  |                           | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeping</b>   |   |   | 16b. Kind of Business/Industry<br><b>Industrial</b>                         |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Leroy Goodwin Sr.</b>  |  |  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Ann Reddick</b>   |   |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cherlyn B. Goodwin Wife</b>   |  |  |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1861 John Drive Edgewood MD 21040</b>   |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Atlantic Crem</b>  |  |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crem</b>  |   |   | Date<br><b>05/04/2012</b>   | 20c. Location - City or Town, State<br><b>Glen Burnie MD</b> |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Thomas Allen PA</b>  |  |  |                           | 22. Name and Address of Facility<br><b>Simplicity Crem &amp; Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD</b>  |   |   |   |  |  |
| Physician /Medical Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End Stage Liver Disease</b><br>Approximate Interval Between Onset and Death   |  |  |                           |   |   |   |   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hepatitis C infection</b>   |  |  |                           |   |   |   |   |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  |                           |   |   |   |   |  |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |  |                           |   |   |   |   |  |  |
|  | 23d. Date of delivery<br>Month Day Year  |  |  |                           |   |   |   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute kidney Failure</b><br><b>Fungemia</b><br><b>Severe Malnutrition (Protein-Calorie)</b>   |  |  |                           |   |   |   |   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |                           |   |   |   |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                           |   |   |   |   |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                           |   |   |   |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |                           |   |   |   |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |  |                           |   |   |   |   |  |  |
|  | 28a. Date of Injury<br>(Month, Day Year)   |  |  |                           |   |   |   |   |  |  |
|  | 28b. Time of Injury  |  |  |                           |   |   |   |   |  |  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |                           |   |   |   |   |  |  |
|  | 28d. Describe how injury occurred  |  |  |                           |   |   |   |   |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                           |   |   |   |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |                           |   |   |   |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                           |   |   |   |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Gedion Atnafu</b>  |  |  |                           |   |   |   |   |  |  |
|  | 29c. License number<br><b>00062148</b>   |  |  |                           |   |   |   |   |  |  |
|  | 29d. Date signed (Month, Day, Year)<br><b>04/29/12</b>   |  |  |                           |   |   |   |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GEDION ATNAFU 7845 Oakwood Rd Suite # 105 Glen Burnie MD 21061</b>  |  |  |                           |   |   |   |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |  |                           |   |   |   |   |  |  |
|  | 32. Registrar's Signature<br><b>Leanne J. Parker</b>   |  |  |                           |   |   |   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

15050

3. Time of Death

2. Date of Death

Month Day Year

May 08 2012

12:45pm

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

RUTH

GOODRICH

4a. Facility Name (if not institution, give street and number)

COURTLAND GARDENS

4b. City, Town, or Location of Death

BALTIMORE

2. Date of Death

Month Day Year

May 08 2012

3. Time of Death

5. Social Security Number

218-03-7112

6. Sex

1  M 2  F

7. Age (in yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

09/11/1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

MD

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

6313 IVY MOUNT ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business Industry

REAL ESTATE LEASING

17. Father's Name (First, Middle, Last)

SAMUEL

MARVEL

18. Mother's Name (First, Middle, Maiden Surname)

RAY

CAPLAN

19a. Informant's Name/Relationship (Type, Print)

SANDRA GREEN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6313 IVY MOUNT ROAD, BALTIMORE, MD 21209

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL CEMETERY

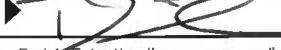
Date

05/10/2012

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

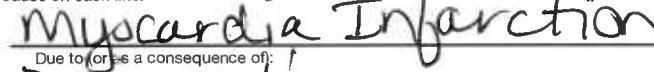
SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):



Approximate Interval Between  
Death and Death

<15 min

Previously list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):



> 6 mo

c. Due to (or as a consequence of):



> 6 mo

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy

4  Pregnant at time of death 5  Other (Specify)

9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural  
2  Accident  
3  Suicide  
4  Homicide

5  Pending Investigation  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

R108614

29d. Date signed (Month, Day, Year)

May 08, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret Corcoran CRNP 18695 Middletown Rd, Parkton, MD 21120

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature



Goodrich, Ruth

Division of Vital Records, P.O. Box 68760

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.  
Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 7/2009

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15051

1- For State Registrar

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GLORIA GREEN</b>   |  |   |  | 2. Date of Death<br>Month <b>05</b> Day <b>09</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>12:45A M</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE HEBREW HOME</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral Director   | 5. Social Security Number<br><b>125-14-4751</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/17/1926</b>                  | 9. Birthplace (State or Foreign Country)<br><b>NY</b>                   |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>HOWARD</b>   |  |   |  | 10c. City, Town or Location <b>COLUMBIA</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>7550 RED CRAVAT COURT</b>  |  |   | 10f. Zip Code<br><b>21046</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>GRAPHIC DESIGNER</b>   |  |  | 16b. Kind of Business/Industry<br><b>GRAPHIC DESIGN</b>                      |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HYMAN</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ARGOFF BESSIE KRAMER</b>   |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERTA GREENSTEIN/DAUGHTER</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7550 RED CRAVAT COURT, COLUMBIA, MD 21046</b>  |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORP</b>   |  | Date<br><b>05/11/2012</b>  | 20c. Location - City or Town, State<br><b>TOWSON, MD</b>                     |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>   |  |   |  |
| Physician /Medical Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>DEMENTIA</b>   |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
|  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |   |  |
|  | a. Due to (or as a consequence of):<br><br><b>DEMENTIA</b>  |  |   |  |  |  |   |  |
|  | b. Due to (or as a consequence of):<br><br>   |  |   |  |  |  |   |  |
|  | c. Due to (or as a consequence of):<br><br>   |  |   |  |  |  |   |  |
|  | d. Due to (or as a consequence of):<br><br>   |  |   |  |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year                                      |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |   |  |
|  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29c. License number<br><b>D0064533</b>  |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br><br><b>PHYSICIAN</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>05-09-2012</b>  |  |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BABATUNDE ASIJI, MD 2434 W. BELVEDERE AVE. BALTIMORE MD 21215</b>  |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

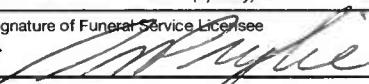
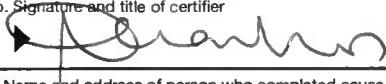
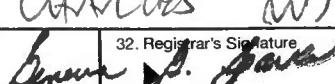
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15052

1 - For  
State  
Registrar

|  |  |   |   |  |  |  |   |  |  |  |
|--|--|---|---|--|--|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Violet E. Holmes</b>  |   |   |  |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>08</b> , Year <b>2012</b> | 3. Time of Death<br>11:08 P M  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>1516 N. Patterson Park Avenue</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |  | 4c. County of Death<br><b>NA</b>                                      |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-38-4868</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>68</b><br>Yrs.  |  | If Under 1 Year<br>Months                                      | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>09-03-43</b>  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>        |  |
|  | Usual Residence of Decedent<br><b>MD</b>   |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>   |  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>1516 N. Patterson Park Avenue</b>   |   |   |  | 10f. Zip Code<br><b>21213</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>10th Grade</b>  |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Food Service</b>                        |  |  | 16b. Kind of Business/Industry<br><b>Johns Hopkins Hospital</b>       |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Leonard Parks</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Lee</b>  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Grand Darnetta D. Buckson-Daughter</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1516 N. Patterson Park Avenue Baltimore, MD. 21213</b> |  |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |   |  | Date<br><b>05-16-12</b>  | 20c. Location - City or Town, State<br><b>Owings Mills, MD</b> |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Wylie Funeral Home P.A.<br/>638 N. Gilmor Street Baltimore, Maryland 21217</b>                                      |  |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast Cancer</b> |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Years</b> |  |
|  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |  |  |  |   |  |  |  |
| a. Due to (or as a consequence of):<br><b>Breast Cancer</b>  |  |   |   |  |  |  |   |  |  |  |
| b. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |   |  |  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |   |  | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   | 23f. Did alcohol contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown     |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                              |   |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>DS8303</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 9 2012</b>              |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AARON J CUTTERES WT 6701 N. Charles ST TOWSON MD</b>  |  |   |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15053

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Huntley

2. Date of Death  
Month Day Year  
May 1, 20123. Time of Death  
6:56 AM<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number  unk6. Sex  
 M  F7. Age (In yrs. last birthday)  
Yrs.  
60If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)  
Jan 25, 19529. Birthplace (State or Foreign  
Country) unk

Usual Residence of Decedent

10a. State MD 10b. County Prince George's 10c. City, Town or Location Forestville 10d. Inside City Limits  
 Yes  No10e. Street and Number  
7420 Marlboro Pike10f. Zip Code  
2074710g. Citizen of What Country?  
USA11. Marital Status unk  
 Never Married  Married  
 Widowed  Divorced12. Was Decedent Ever in U.S. Armed Forces?  
 Yes  No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: black15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) unk  
College (1-4 or 5+) unk16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)  
unk16b. Kind of Business/Industry  
unk

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

unk

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unk

20a. Method of Disposition  
 Burial  Cremation  Removal from State  
 Donation  Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee Ronald S. Davis, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

FATAL

Cardiac Arrest

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify) \_\_\_\_\_  
 Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

 Yes  No  Probably  Unknown25. Was case referred to medical examiner?  
 Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of injury  
M

28c. Injury at work?

 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number  
400 636 88

29d. Date signed (Month, Day, Year)

MAY 3, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRiffin Davis 3001 Hospital Dr. Cheverly, MD. 20785

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature

Ronald S. Davis

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2012 19034

|   |  |   |  |  |  |   |   |  |  |   |
|---|--|---|--|--|--|---|---|--|--|---|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Carl Marshall Henry</b>  |  |  |  |   |   | 2. Date of Death<br>Month <b>5</b> Day <b>8</b> Year <b>2012</b>           | 3. Time of Death<br><b>740 PM</b>                              |   |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>FRANKLIN Square Hospital</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   |   | 4c. County of Death<br><b>Baltimore</b>                                    |  |   |
| Funeral<br>Director                           |  | 5. Social Security Number<br><b>220-64-5630</b>   |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>56 Yrs.</b>   |   | If Under 1 Year<br>Months                     | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 24, 1955</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   |  | Usual Residence of Decedent<br><b>Md. Baltimore</b>   |  | 10a. State<br><b>Md.</b> 10b. County<br><b>Baltimore</b>   |  |   | 10c. City, Town or Location<br><b>Dundalk</b> |  |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                |
| To Be Completed by Funeral Director           |  | 10e. Street and Number<br><b>7522 Ives Lane</b>   |  |  |  | 10f. Zip Code<br><b>21222</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>                    |   |
|   |  | 11. Marital Status<br><b>1 Never Married 2 Married<br/>3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No<br/>If Yes, Give Year or Dates.</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b> |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>    |  |   |
| To Be Completed by Funeral Director           |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10 years</b>   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Driver</b>    |   |   | 16b. Kind of Business/Industry<br><b>Trucking</b>                          |  |   |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Howard Lowell Henry Sr.</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Elizabeth Zellers</b>  |   |   |  |  |   |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Clara E. Hall Mother</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>202 Robwood Road, Dundalk, Md. 21222</b>         |   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>          |  |   |
|   |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State<br/>4 Donation 5 Other (Specify)</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>   |   |   | Date<br><b>May 10, 2012</b>  |  |   |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b>► Anthony Connally</b>  |  |  | 22. Name and Address of Facility<br><b>Connally Funeral Home of Dundalk, P.A.<br/>7110 Sollers Point Road, Dundalk, Md. 21222</b>                    |   |   |  |  |   |
|   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)  |  |  | 23b. Approximate Interval Between Onset and Death  |   |   |  |  |   |
| To Be Completed by Physician/Medical Examiner |  | 23c. Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  | 23d. Due to (or as a consequence of):  |   |   |  |  |   |
|   |  | a. <b>Pulmonary Embolism</b><br>Due to (or as a consequence of):  |  |  | b. <b>Pneumonia</b><br>Due to (or as a consequence of):  |   |   | c. <b>metastatic pancreatic cancer</b><br>Due to (or as a consequence of): |  |   |
| To Be Completed by Physician/Medical Examiner |  | 23e. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No<br/>9 Unknown</b>   |  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death<br/>4 Pregnant at time of death<br/>9 Unknown</b>                                 |   |   | 23d. Date of delivery<br>Month Day Year                                    |  |   |
|   |  | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  | 23f. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |   |  |  |   |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |   |   | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>                        |  |   |
|   |  | 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b>   |  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>28b. Time of injury<br/>M</b>  |   | 28c. Injury at work?<br><b>1 Yes 2 No</b>     |  | 28d. Describe how injury occurred                              |   |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |   |
|   |  | 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  | 29b. Signature and title of certifier<br><b>► Danica Dorotaj, M.D.</b>   |   |   | 29c. License number<br><b>D70229</b>                                       |  | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b>   |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR Danica Dorotaj 8000 FRANKLIN Square DR Balt MD 21237</b>  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |   |   | 32. Registrar's Signature<br><b>Susan J. Parker</b>                        |  |   |
|   |  | State<br>Registrar  |  |  |  |   |   |  |  |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15055

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |                                    |  |  |  |                  |
|--|------------------------------------|--|--|--|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year |  |  |  | 3. Time of Death |
| Carl Lewis Hamby                         | MAY 7TH 2012                       |  |  |  | 1820 PM          |

|  |                                      |  |  |  |                     |
|--|--------------------------------------|--|--|--|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death |  |  |  | 4c. County of Death |
| PENNSYLVANIA REGIONAL MEDICAL CENTER                           | SALISBURY                            |  |  |  | MICOMARCO           |

Funeral  
Director

|                           |  |                                |                 |                  |  |  |
|---------------------------|--|--------------------------------|-----------------|------------------|--|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| 215-28-6413               | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 81 Yrs.                        | Months          | Days             | Hours                                  | Min.                                     |
|                           |  |                                |                 | Jan. 3, 1931     |  |  |

|            |             |                             |  |  |  |  |
|------------|-------------|-----------------------------|--|--|--|--|
| 10a. State | 10b. County | 10c. City, Town or Location |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| Maryland   | Harford     | Havre de Grace              |  |  |  |  |

|                            |               |                               |
|----------------------------|---------------|-------------------------------|
| 10e. Street and Number     | 10f. Zip Code | 10g. Citizen of What Country? |
| 605 Concord Street, Unit J | 21078         | USA                           |

|  |   |   |  |
|--|---|---|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |   |  |

|  |  |                                |
|--|--|--------------------------------|
| 15. Decedent's Education<br>(Specify only highest grade completed) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| Elementary/Secondary (0-12) 12                                     | College (1-4 or 5+) Equipment Manual Specialist  | U.S. Government                |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| Edward Webster Hamby                    | Nora Gross  |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Lucile K. Hamby / Wife                           | 605 Concord Street, Unit J, Havre de Grace, Maryland 21078                                    |

|   |  |           |                                     |
|---|--|-----------|-------------------------------------|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date      | 20c. Location - City or Town, State |
|   | Mt. Zion UMC Cemetery  | 5/11/2012 | Bel Air, Maryland                   |

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility  |
|   | McComas Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Maryland 21009 |

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. Due to (or as a consequence of):<br><br><br><br>b. Due to (or as a consequence of):<br><br><br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |  |

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |  |
|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |

|   |   |  |
|---|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|---|--|

|   |  |                          |  |  |
|---|--|--------------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|   |
|---|
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|---|

|   |                               |   |
|---|-------------------------------|---|
| 29b. Signature and title of certifier<br> | 29c. License number<br>DMV715 | 29d. Date signed (Month, Day, Year)<br>5/8/12 |
|---|-------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |
| STEVEN HARGLE 100 E. CARROLL ST. SALISBURY, MD 21801                                 |

|  |                               |
|--|-------------------------------|
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012 | 32. Registrar's Signature<br> |
|--|-------------------------------|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend Item 27 per me, g927, 05/11/2012dhb Certificate of Death

Reg. No.

2012 15056

|  |   |  |  |  |                                      |  |  |   |  |
|--|---|--|--|--|--------------------------------------|--|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>KENNETH B JOHNSON</b>  |  |  | 2. Date of Death<br><b>APRIL 15 2012</b>   |                                      | 3. Time of Death<br><b>140 PM</b>                            |  |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>MERCY HOSPITAL</b>   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                      | 4c. County of Death<br><b>BALTIMORE</b>                      |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>243-08-2980</b>   | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>52 Yrs.</b> | If Under 1 Year<br>Months<br><b>0</b>  | If Under 24 Hrs.<br>Days<br><b>0</b> | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT 3, 1959</b> | 9. Birthplace (State or Foreign Country)<br><b>UNK</b>   |   |  |
|  | Usual Residence of Decedent<br><b>MARYLAND</b>  |  |  | 10a. State<br><b>MD</b>  |                                      |  | 10b. County<br><b>BALTIMORE</b>  |   | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>           |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>620 Fallsway</b>   |  |  | 10f. Zip Code<br><b>21202</b>  |                                      |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><b>UNK</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 No 2 X Yes</b><br>If Yes, Give Year or Dates.<br><b>1959</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 No 2 X Yes</b><br>Specify:<br><b>white</b> |                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                       |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>                         |                                      |  | 16b. Kind of Business/Industry<br><b>UNK</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Mercy Hospital</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unk</b>  |                                      |  | <b>unk</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mercy Hospital</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301 St. Paul Place Baltimore, MD 21202</b>                     |                                      |  |  |   |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state</b>  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>unk</b>   |                                      |  | 20c. Date<br><b>unk</b>  |   |  |
|  | 21. Signature of Funeral Service Umpire<br><b>Ronald S. Costa, Director</b>   |  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |                                      |  |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sub DURAL Hematoma</b>   |  |  | 23b. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  | Appropriate Interval Between Onset and Death<br><b>unk</b>                                       |   |  |
|  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  | 23d. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23e. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23f. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23g. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23h. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23i. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23j. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23k. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23l. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23m. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23n. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23o. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23p. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23q. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23r. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23s. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23t. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23u. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23v. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23w. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23x. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 23y. Due to (or as a consequence of):<br><b>unk</b>   |  |  | 23z. Due to (or as a consequence of):<br><b>unk</b>  |                                      |  |  |   |  |
|  | 24a. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 3 Unknown</b>   |  |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown</b>                 |                                      |  | 23d. Date of delivery<br>Month Day Year  |   |  |
|  | 24e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |  |  | 24f. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |                                      |  | 24g. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |   |  |
|  | 25. Was case referred to medical examiner?<br><b>1 X Yes 2 No</b>   |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>             |                                      |  |  |   |  |
|  | 27. Manner of Death<br><b>1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>4/16/12</b>  |                                      |  | 28b. Time of Injury<br><b>1500 PM</b>  | 28c. Injury at work?<br><b>1 Yes 2 X No</b> | 28d. Describe how injury occurred<br><b>Subject fell</b> |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway/Sidewalk</b>   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>300 N. Calvert St. Baltimore, MD</b>  |                                      |  |  |   |  |
|  | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  | 29c. License number<br><b>D42634</b>   |                                      |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 15, 2012</b>                                     |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH COSTA</b>   |  |  | 32. Registrar's Signature<br><b>Joseph S. Costa</b>  |                                      |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |   |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

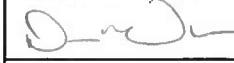
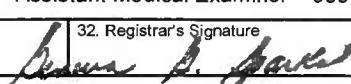
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15057

**1- For State Registrar**

|   |  |   |  |  |  |  |   |   |   |   |
|---|--|---|--|--|--|--|---|---|---|---|
| <b>Physician/<br/>Medical Examiner</b>                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Don Ermine Jones Jr.</b>  |   |  |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>May 8, 2012</b>  | 3. Time of Death<br>1041 hrs  |   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  |   | 4c. County of Death<br><b>Harford</b>   |   |   |
| <b>Funeral Director</b>   | 5. Social Security Number<br><b>215-58-3719</b>  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>59</b>  | Yrs.   | If Under 1 Year<br>Months Days Hours Min.<br><b></b>   | 8. Date of Birth (MM/DD/YYYY)<br><b>Aug. 11, 1952</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |   |   |   |
|   | 10a. State<br><b>Maryland</b> 10b. County<br><b>Harford</b> 10c. City, Town or Location<br><b>Bel Air</b>  |   |  |  |  |  |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |   |
| <b>To Be Completed by Funeral Director</b>                                  | 10e. Street and Number<br><b>1400 Prospect Mill Road</b>   |   |  |  | 10f. Zip Code<br><b>21015</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |
|   | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>   |  |  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |   |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>                          |  |  | 16b. Kind of Business/Industry<br><b>Public School</b>                  |   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Don Ermine Jones Sr.</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Virginia Baldwin</b>                                      |  |   |   |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Clare Jones / Wife</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1400 Prospect Mill Road, Bel Air, Maryland 21015</b> |  |  |   |   |   |   |
|   | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill SVCS., LLC</b>  |  |  | Date<br><b>5-14-2012</b>  | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>   |   |   |
|   | 21. Signature of Funeral Service Licensee<br>   |   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>                                      |  |  |   |   |   |   |
| <b>Physician /Medical examiner</b>  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  |  |  |   |   | Approximate Interval Between Onset and Death  |   |
|   | <input type="checkbox"/> UNPENDED  | <input checked="" type="checkbox"/> AMENDED   | #1perME.C927.5/11/2012.WS  |  |  |  |   |   |   |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b> |  |  |  | 23d. Date of delivery<br>Month Day Year                                 |   |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |
|   |  |   |  |  |  |  |   |   | 24a. Was an autopsy performed?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
|   | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:</b>     |  |  |  |   |   |   |   |
|   | 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br/>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |   | 28a. Date of Injury (Month, Day, Year)<br><b>May 8, 2012</b>   |  | 28b. Time of Injury<br><b>1007 hrs</b>   | 28c. Injury at Work?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred<br><b>Driver auto auto collision</b>  |   |   |   |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>(Specify) Major Road / Highway</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>800 Mountain Road, Fallston, MD</b> |  |   |   |   |   |
|   | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>one)</b><br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>   |  |  |  |   |   | 29c. License number<br><b>O.C.M.E.</b>  | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |   |  |  |  |  |   |   |   |   |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b> | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |   | 32. Registrar's Signature<br>   |  |  |  |   |   | ORIGINAL  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15058

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death<br>Month <u>5</u> Day <u>9</u> Year <u>2012</u>  |   | 3. Time of Death<br><u>8:45 A M</u>  |
| Nathaniel A. Jenkins  |  |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>  |   | 4c. County of Death  |
| 4a. Facility Name (if not institution, give street and number)<br><u>Future Care Lochearn</u>   |  |   | If Under 1 Year<br>Months <u>83</u> Yrs.  | If Under 24 Hrs.<br>Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  | 8. Date of Birth<br>(Month, Day, Year)<br><u>1-4-1929</u>                        |
| 5. Social Security Number<br><u>055-20-7600</u>   |  |   | 6. Sex<br><u>1</u> M <u>2</u> F   | 7. Age (In yrs. last birthday)  | 9. Birthplace (State or Foreign Country)<br><u>NY</u>                            |
| Usual Residence of Decedent<br>10a. State <u>MD</u> 10b. County <u>Baltimore</u> 10c. City, Town or Location <u>Windsor Mill</u>  |  |   |   |   | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                              |
| 10e. Street and Number<br><u>7907 Cantwell Road</u>   |  |   | 10f. Zip Code<br><u>21244</u>   |   | 10g. Citizen of What Country?<br><u>USA</u>                                      |
| 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates.                              |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No<br>Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><u>Photographer</u> |   | 16b. Kind of Business Industry<br><u>Photography</u>  |  |
| 17. Father's Name (First, Middle, Last)<br><u>John Lloyd Jenkins</u>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Bertha Mae Cobb</u>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Delores E. Jenkins/Wife</u>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7907 Cantwell Road, Windsor Mill, MD 21244</u>  |   |  |
| 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Arbutus Park</u>   |   | Date <u>5-18-2012</u> 20c. Location - City or Town, State<br><u>Baltimore MD</u> |
| 21. Signature of Funeral Service Licensee<br><u>Vaughn C. Greene</u>  |  |   | 22. Name and Address of Facility Vaughn C. Greene Funeral Services<br><u>8728 Liberty Road, Randallstown, MD 21133</u>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   | Approximate Interval Between Onset and Death<br><u>1 week</u>   |   |  |
| a. Due to (or as a consequence of):<br><u>Underexposure</u>   |  |   |   |   |  |
| b. Due to (or as a consequence of):   |  |   |   |   |  |
| c. Due to (or as a consequence of):   |  |   |   |   |  |
| d. _____  |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><u>1</u> Yes <u>2</u> No <u>9</u> Unknown  |  |   | 23c. If yes, outcome of pregnancy<br><u>1</u> Live Birth <u>2</u> Fetal death <u>3</u> Ectopic pregnancy<br><u>4</u> Pregnant at time of death <u>5</u> Other (specify) _____<br><u>9</u> Unknown |   |  |
| 23d. Date of delivery<br>Month _____ Day _____ Year _____   |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown   |   |  |
|   |  |   | 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No  |   |  |
|   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No   |   |  |
| 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)                  |   |  |
| 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>7</u> Homicide  |  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><u>1</u> Yes <u>2</u> No                                 |
|   |  |   | 28d. Describe how injury occurred   |   |  |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
|   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><u>Karen W. Jenkins MD</u>   |  |   | 29c. License number<br><u>00043375</u>  | 29d. Date signed (Month, Day, Year)<br><u>05/09/2012</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Karen W. Jenkins MD 6934 AVIATION Blvd Suite N-2 Green Brook NJ 08812</u>  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAY 11 2012</u>   |  |   | 32. Registrar's Signature<br><u>Suzanne S. Sparks</u>   |   |  |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15059

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |                           |                  |
|--|---------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month | 3. Time of Death |
| Ramona Elizabeth Jones                   | May 9, 2012               | Year<br>2330 M   |

Funeral  
Director

|  |  |                                |                 |                  |  |  |            |    |
|--|--|--------------------------------|-----------------|------------------|--|--|------------|----|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death                                 | 4c. County of Death            |                 |                  |  |  |            |    |
| Gilchrist Hospice  | Towson   | Baltimore                      |                 |                  |  |  |            |    |
| 5. Social Security Number                                      | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |            |    |
| 215-66-3876  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 54 Yrs.                        | Months          | Days             | Hours                                  | Min.                                     | 06/28/1957 | MD |

|            |             |                             |  |
|------------|-------------|-----------------------------|--|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| MD         | n/a         | Baltimore                   |  |

|                           |               |                               |
|---------------------------|---------------|-------------------------------|
| 10e. Street and Number    | 10f. Zip Code | 10g. Citizen of What Country? |
| 3414 West Franklin Street | 21229         | USA                           |

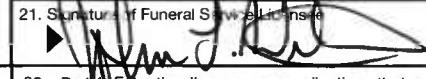
|                    |   |  |  |
|--------------------|---|--|--|
| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
|--------------------|---|--|--|

|  |  |                                |
|--|--|--------------------------------|
| 15. Decedent's Education<br>(Specify only highest grade completed) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| Elementary/Secondary (0-12) 12                                     | College (1-4 or 5+) Correctional Officer   | Penal System                   |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| James Wilson Martin                     | Josephine Joyce McIntosh                          |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Kiana Jones / Daughter                           | 2094 Streamway Ct Gwynn Oak, MD 21207   |

|  |  |            |                                     |
|--|--|------------|-------------------------------------|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date       | 20c. Location - City or Town, State |
|  | King Memorial Park   | 05.15.2012 | Randallstown, MD                    |

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee   | 22. Name and Address of Facility  |
|  | John L. Williams Funeral Directors, P.A.<br>4517 Park Heights Ave Baltimore, MD 21215 |

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death<br>months |
| a. Due to (or as a consequence of):<br><br><i>Pancreatic cancer</i>  |  |

|                                     |  |
|-------------------------------------|--|
| b. Due to (or as a consequence of): |  |
| c. Due to (or as a consequence of): |  |
| d. Due to (or as a consequence of): |  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

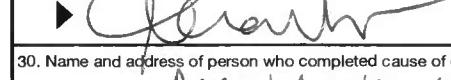
|   |   |
|---|---|
| 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|---|

|   |   |   |
|---|---|---|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i> |
|---|---|---|

|  |   |                          |  |                                   |
|--|---|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury<br>(Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|---|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|   |
|---|
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|---|

|  |                                      |   |
|--|--------------------------------------|---|
| 29b. Signature and title of certifier<br> | 29c. License number<br><i>DS8303</i> | 29d. Date signed (Month, Day, Year)<br><i>MAY 10 2012</i> |
|--|--------------------------------------|---|

|  |   |  |
|--|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i> | 32. Registrar's Signature<br> |
|--|---|--|

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15060

1. For State  
Registrar**Physician/  
Medical Examiner**

Reg. No.

|   |  |   |  |  |  |   |
|---|--|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |  |  |  | 3. Time of Death<br>0615 hrs  |
| <b>Jeffrey Johnston</b>   |  | May 9, 2012   |  |  |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>                    |  |  | 4c. County of Death<br><b>Baltimore County</b>  |
| 5. Social Security Number<br><b>294-66-9891</b>   |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>44</b>                                | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth (MM/DD/YYYY)<br><b>3-19-1968</b>              | 9. Birthplace (State or Foreign Country)<br><b>ILLINOIS</b>                                       |
| Usual Residence of Decedent<br>10a. State<br><b>Ohio</b> 10b. County<br><b>DARKE</b> 10c. City, Town or Location<br><b>Greenville</b> 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |   |  |  |  |   |
| 10e. Street and Number<br><b>4692 HOGPATH ROAD</b>  |  |   | 10f. Zip Code<br><b>45331</b>  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |  | 16b. Kind of Business/Industry<br><b>Precision Motor Transport Group</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles William Johnston</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marilyn GARNER</b> |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHARON Johnston - Spouse</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4692 HOGPATH ROAD Greenville, Ohio 45331</b>  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><b>CHPZ</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAK Grove Cen.</b>   |  | Date<br><b>5-17-2012</b>   | 20c. Location - City or Town, State<br><b>Greenville, Ohio</b> |   |
| 21. Signature of Funeral Service Licensee<br><b>CHPZ</b>  |  | 22. Name and Address of Facility<br><b>Joseph N ZANNINO JR PH-263 S. Conkling St Bldg M&amp; 21224</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. _____<br>c. _____<br>d. _____  |  |   |  |  |  |   |
| <input checked="" type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g927 5-29-12 sm   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year                        |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:                 |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury  | 28c. Injury at Work?   | 28d. Describe how injury occurred<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   |  |   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)            |
|   |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                      |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Jeffrey Johnston</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b>      |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne J. Baker</b>   |  |  |  |   |

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State  
Registrar**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15061

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that a death certificate be executed within 24 hours after death.

## **Medical Certification: To Be Completed by Physician/Medical Examiner**

Baltimore: MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

## To Be Completed by Funeral Director

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15062

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

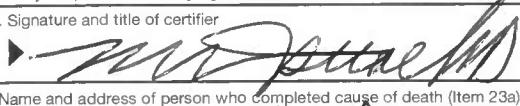
Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Division of Vital Records, P.O. Box 68760

|  |   |   |  |  |                                   |   |  |
|--|---|---|--|--|-----------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month Day Year  |  |  |                                   | 3. Time of Death  |  |
| <i>Sarah Konig</i>   |   | MAY 09, 2012  |  |  |                                   | 4:22 A M  |  |
| 4a. Facility Name (if not institution, give street and number)   |   | 4b. City, Town, or Location of Death  |  |  |                                   | 4c. County of Death   |  |
| atrium village   |   | owings mills  |  |  |                                   | baltimore   |  |
| 5. Social Security Number  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs.                                    | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days          | 8. Date of Birth<br>(Month Day Year)<br>10/29/1920  | 9. Birthplace (State or Foreign Country)<br>MD       |
| 216-09-5830  |   |   |  |  |                                   |   |  |
| Usual Residence of Decedent  |   |   |  |  |                                   |   |  |
| 10a. State<br>MD   | 10b. County<br>BALTIMORE  | 10c. City, Town or Location<br>OWINGS MILLS   |  |  |                                   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        |  |
| 10e. Street and Number<br>4730 ATRIUM COURT, #422  |   | 10f. Zip Code<br>21117  |  |  |                                   | 10g. Citizen of What Country?<br>USA  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                      |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) CLAIMS ANALYST  |  |  |                                   | 16b. Kind of Business Industry<br>SOCIAL SECURITY ADMINISTRATION                                      |  |
| 17. Father's Name (First, Middle, Last)<br>GERSHON   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>LUSTMAN IDA RICHTER  |  |  |                                   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>LINDA FINIFTER/DAUGHTER  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3119 OLD POST DRIVE, BALTIMORE, MD 21208   |  |  |                                   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SHAAREI ZION CEMETERY   |  |  |                                   | Date<br>05/10/2012  | 20c. Location - City or Town, State<br>BALTIMORE, MD |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208  |  |  |                                   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Atherosclerotic Heart Disease</i>   |   |   |  |  |                                   |   |  |
| Approximate Interval Between Onset and Death<br><i>20 years</i>  |   |   |  |  |                                   |   |  |
| b. Due to (or as a consequence of):<br><i>Aortic stenosis</i>  |   |   |  |  |                                   |   |  |
| c. Due to (or as a consequence of):  |   |   |  |  |                                   |   |  |
| d. Due to (or as a consequence of):  |   |   |  |  |                                   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |  |                                   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |                                   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |                                   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                   | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |   |  |
|  |   |   | M  |  |                                   |   |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |                                   |   |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D17803   |  |  |                                   | 29d. Date signed (Month, Day, Year)<br>05/10/2012   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>WARREN ISRAEL MD 1838 Greene tree Road #535 Baltimore Maryland 21208   |   |   |  |  |                                   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |   | 32. Registrar's Signature<br>  |  |  |                                   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15063

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| <b>Frances Kleeman</b>                   | 05 08 2012                         | 20:45 PM         |

4a. Facility Name (if not institution, give street and number)  
**University of Maryland Medical Center  
22 South Greene Street**4b. City, Town, or Location of Death  
**Baltimore**4c. County of Death  
**N/A****Funeral  
Director**

|                           |  |                                |  |  |
|---------------------------|--|--------------------------------|--|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| <b>131-26-8531</b>        | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 76 Yrs.                        | <b>03/23/1936</b>                      | NY                                       |

Usual Residence of Decedent

|            |              |                             |  |
|------------|--------------|-----------------------------|--|
| 10a. State | 10b. County  | 10c. City, Town or Location | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| <b>PA</b>  | <b>BUCKS</b> | <b>WARMINSTER</b>           |  |

|                          |               |                               |
|--------------------------|---------------|-------------------------------|
| 10e. Street and Number   | 10f. Zip Code | 10g. Citizen of What Country? |
| <b>128 FAIRWAY DRIVE</b> | <b>18974</b>  | <b>USA</b>                    |

|  |   |   |   |
|--|---|---|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
|--|---|---|---|

|   |   |  |
|---|---|--|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>4<br>TEACHER | 16b. Kind of Business/Industry<br><b>EDUCATION</b> |
|---|---|--|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>HARRY BOCHBINDER</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SALLY BRAUNSTEIN</b> |
|--|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LEONARD KLEEMAN/HUSBAND</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>128 FAIRWAY DRIVE, WARMINSTER, PA 18974</b> |
|--|---|

|  |  |      |  |
|--|--|------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>SHALOM MEMORIAL PARK</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State<br><b>LOWER MORELAND, PA</b> |
|--|--|------|--|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br><b>Marty Le</b> | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b> |
|--|--|

|  |  |
|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. <b>ST elevation myocardial infarction</b><br>Due to (or as a consequence of):   |  |
| b. _____<br>Due to (or as a consequence of):   |  |
| c. _____<br>Due to (or as a consequence of):   |  |
| d. _____   |  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |   |
|---|---|
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|---|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|--|

|  |   |
|--|---|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred |
|--|---|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |
|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|--|

|  |                                      |  |
|--|--------------------------------------|--|
| 29b. Signature and title of certifier<br><b>Tessy Paul Hospitalist Physician</b> | 29c. License number<br><b>D72512</b> | 29d. Date signed (Month, Day, Year)<br><b>05/08/12</b> |
|--|--------------------------------------|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tessy Paul, MD, 22 South Greene Street, Baltimore MD 21201</b> |
|---|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b> | 32. Registrar's Signature<br><b>Leanne A. Parker</b> |
|---|--|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**State  
Registrar**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15064

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1244 hrs |
| DANE MICHAEL LYNCH                       | May 9, 2012                        |                              |

|  |   |                             |
|--|---|-----------------------------|
| 4a. Facility Name (if not institution, give street and number)<br>3828 Fait Avenue | 4b. City, Town, or Location of Death<br>Baltimore | 4c. County of Death<br>None |
|--|---|-----------------------------|

**Funeral Director**

|  |  |   |                                |                               |   |  |
|--|--|---|--------------------------------|-------------------------------|---|--|
| 5. Social Security Number<br>216-76-7841 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>40 Yrs. | If Under 1 Year<br>Months Days | If Under 24Hrs.<br>Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>03/20/1972 | 9. Birthplace (State or Foreign Country)<br>Maryland |
|--|--|---|--------------------------------|-------------------------------|---|--|

|                        |                     |  |  |
|------------------------|---------------------|--|--|
| 10a. State<br>Maryland | 10b. County<br>None | 10c. City, Town or Location<br>Baltimore | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|------------------------|---------------------|--|--|

|  |                        |                                      |
|--|------------------------|--------------------------------------|
| 10e. Street and Number<br>3828 Fait Avenue | 10f. Zip Code<br>21224 | 10g. Citizen of What Country?<br>USA |
|--|------------------------|--------------------------------------|

|  |  |   |  |
|--|--|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: White | 14. Race - American Indian, Black, White, etc. |
| 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                            | If Yes, Give Year or Dates:  |   |  |

|  |  |   |
|--|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>5+ | 16b. Kind of Business/Industry<br>Analyst |
|--|--|---|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br>Dane Lynch | 18. Mother's Name (First, Middle, Maiden Surname)<br>Barbara Lee Podles |
|---|---|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Leon J Podles | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Uncle 104 Longwood Road Baltimore, Maryland 21210 |
|---|--|

|   |  |                    |  |
|---|--|--------------------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St Mary's Cemetery | Date<br>05/14/2012 | 20c. Location - City or Town, State<br>Baltimore, Maryland |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  |                    |  |

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br>Dennis Stephen Venakos | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home Inc<br>6500 York Road Baltimore, Maryland 21212 |
|---|---|

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |   |
|---|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of): |

|  |  |
|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |
|--|--|

|  |  |
|--|--|
| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |
|--|--|

|  |   |
|--|---|
| <input checked="" type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g928 6-21-12 sm |
|--|---|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|                |   |  |
|----------------|---|--|
| <b>Obesity</b> | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|----------------|---|--|

|   |   |  |  |
|---|---|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |  |
|---|---|--|--|

|  |  |                     |  |                                   |
|--|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|   |
|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

|   |                                 |   |
|---|---------------------------------|---|
| 29b. Signature and title of certifier<br><i>Ana Rubio</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 10, 2012 |
|---|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|---|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012 | 32. Registrar's Signature<br><i>Laura J. Pace</i> |
|--|---|

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15065

**1 - For  
State  
Registrar**

|   |   |  |   |  |  |  |  |   |
|---|---|--|---|--|--|--|--|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Jingping Lin</b>   |  |   |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>5</b> Year <b>2012</b>   |  | 3. Time of Death<br>10:35 M   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>637-05-6080</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-23-1957</b>   | 9. Birthplace (State or Foreign Country)<br><b>China</b>                                       |   |
|   | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Montgomery</b>   |  |   | 10c. City, Town or Location<br><b>Montgomery Villiage</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <b>To Be Completed by Funeral Director</b>  | 10e. Street and Number<br><b>10026 Stedwick Road</b>  |  |   | 10f. Zip Code<br><b>20886</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b> |
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) <b>5+</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Scientist</b>             |  |  | 16b. Kind of Business Industry<br><b>Government</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Junde Lin</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Renci Xiao</b>   |  |  |  |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jieping Lin - Brother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10026 Stedwick Road, Montgomery Villiage, Maryland 20886</b> |  |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Crematory</b>  |  |  | Date<br><b>5-14-2012</b>   | 20c. Location - City or Town, State<br><b>Falls Church Virginia</b>     |
| 21. Signature of Funeral Service Licensee<br><br><b>Kurt Blake</b><br>M01477  |   |  | 22. Name and Address of Facility<br><b>Danzansky-Goldberg</b><br><b>1170 Rockville Pike, Rockville, Maryland 20852</b>  |  |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>cardiopulmonary arrest</b><br>Due to (or as a consequence of):<br>b. <b>metastatic non small cell lung cancer to brain</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Approximate Interval Between Onset and Death                                    |   |  |   |  |  |  |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  |  | 23f. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  | 29c. License number<br><b>D0047512</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 5, 2012</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Madan Bangalore, MD 9901 Medical center Drive, Rockville, Maryland 20850</b>   |   |  |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   |  | 32. Registrar's Signature<br>  |  |  |  |  |   |

**Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15066

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Rosa.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|                                     |  |   |   |  |  |  |  |
|-------------------------------------|--|---|---|--|--|--|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death<br>8 13 M   |  |
| Physician/<br>Medical<br>Examiner   |  | Rosa Mae Lewis  |   | May 9 2012   |  |  |  |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br>ST AGNES HOSPITAL   |   | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death  |  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br>216-30-0579  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>76 Yrs.  | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>7-1-1935   | 9. Birthplace (State or Foreign Country)<br>NC |
|                                     |  | 10a. State<br>MD  | 10b. County   | 10c. City, Town or Location<br>Baltimore   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     |  | 10e. Street and Number<br>509 N. Loudon Avenue  |   | 10f. Zip Code<br>21229   | 10g. Citizen of What Country?<br>USA   |  |  |
|                                     |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                 |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>12th  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor  | 16b. Kind of Business/Industry<br>St. Vincents   |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br>Russell Sanders  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eva Battle   |  |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type or Print)<br>Tense Rodgers-Smith   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>520 Lyndhurst St., Baltimore, MD 21229   |  |  |  |  |
|                                     |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ring Park   | Date<br>5-16-12  | 20c. Location - City or Town, State<br>Windsor Mill, MD                          |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br>Vaughn C. Greene   | 22. Name and Address of Facility<br>Vaughn C. Greene Funeral Services<br>5151 Baltimore National Pike (21229)   |  |  |  |  |
|                                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sepsis  |   |  |  | Approximate Interval Between Onset and Death<br>20 days.   |  |
|                                     |  | a. Due to (or as a consequence of):<br>Pneumonia  |   |  |  |  |  |
|                                     |  | b. Due to (or as a consequence of):<br>cerebrovascular accident.  |   |  |  |  |  |
|                                     |  | c. Due to (or as a consequence of):<br>Encephalopathy.  |   |  |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Peripheral vascular disease<br>Sarcoid disorder<br>Hyper tension  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | Hospital:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                          |  |  |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                     |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |
|                                     |  | 29b. Signature and title of certifier<br>A Abdelsayed, MD   | 29c. License number<br>P 26428  | 29d. Date signed (Month, Day, Year)<br>May 9th 2012  |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>900 Carlton Avenue Baltimore MD.  |   |  |  |  |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br>MAY 11 2012  | 32. Registrar's Signature<br>Caron J. Parker  |  |  |  |  |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15067

1- For  
State  
Registrar

|  |  |  |   |  |  |   |   |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|---|--|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Theresa Lanahan</b>   |  |   |  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>May 9, 2012</b>                     |   |  | 3. Time of Death<br>Hour Minute AM PM<br><b>8:30 PM</b>  |   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Overlea Health &amp; Rehabilitation</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |   |   | 4c. County of Death<br><b>Baltimore</b>                                      |   |  |  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-05-9666</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93 Yrs.</b> |  | If Under 1 Year<br>Months Days Hours Min.   |   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sep. 21, 1918</b>               |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |
|  | Usual Residence of Decedent<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Abingdon</b>           |   |   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>3807 C Memory Lane</b>  |  |   |  |  | 10f. Zip Code<br><b>21009</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>Elementary/Secondary (0-12) 10</b>  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b>   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify:  |  |  |   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>   |  |   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Urology Registrar</b>  |   |  | 16b. Kind of Business/Industry<br><b>Hospital</b>   |  |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George (nmn) Riehl</b>   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Elizabeth Kroener</b>   |   |  |   |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lawrence S. Lanahan / Step Son</b>  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1503 Marlboro Ct., Bel Air, MD 21014</b>  |   |  |   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Moreland Memorial Park</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |  |  | Date<br><b>5-14-2012</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |   |  |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |   |  |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>   |   |  |   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | Approximate Interval Between Onset and Death<br><b>30 minutes</b> |  |  |
|  | {  |  |   |  |  | a. Due to (or as a consequence of):<br><b>Cardiac arrhythmias</b>   |   |  |   | 15 yrs   |  |   |  |  |
|  | {  |  |   |  |  | b. Due to (or as a consequence of):<br><b>Atherosclerotic heart disease</b>   |   |  |   | 11   |  |   |  |  |
|  | {  |  |   |  |  | c. Due to (or as a consequence of):<br><b>Hypertension</b>  |   |  |   | 11   |  |   |  |  |
|  | {  |  |   |  |  | d. Due to (or as a consequence of):<br><b>Dementia</b>  |   |  |   |  |  |   |  |  |
| Division of Vital Records, P.O. Box 68760<br><i>65.</i>  | IF FEMALE:   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |   |  |   |  |  |   |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |   |  |  |
| A  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M                                 | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                                 |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Nurse Practitioner  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  | 29c. License number<br><b>D 30494</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5-10-2012</b>   |  |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Nurse Practitioner  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  | 29c. License number<br><b>D 30494</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5-10-2012</b>   |  |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K DESAI MD 16 Maiden Choice Lane 302 Baltimore MD 21228</b>   |  |   |  |  |   |   |  |   |  |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month Day Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |   |  |   |  |  |   |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15068

**1- For State Registrar****Physician/Medical Examiner**

|  |                                    |  |  |  |                              |
|--|------------------------------------|--|--|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year |  |  |  | 3. Time of Death<br>1412 hrs |
| Lolisa Antoinette Murray                 | May 1, 2012                        |  |  |  |                              |

**Funeral Director**

|  |   |  |  |                            |
|--|---|--|--|----------------------------|
| 4a. Facility Name (if not institution, give street and number)<br>Johns Hopkins Hospital | 4b. City, Town, or Location of Death<br>Baltimore |  |  | 4c. County of Death<br>N/A |
|--|---|--|--|----------------------------|

**To Be Completed by Funeral Director**

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

|  |  |   |                                |                                |  |  |
|--|--|---|--------------------------------|--------------------------------|--|--|
| 5. Social Security Number<br>218-86-6684 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>46 Yrs. | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>Feb. 22, 1966 | 9. Birthplace (State or Foreign Country)<br>Maryland |
|--|--|---|--------------------------------|--------------------------------|--|--|

|                             |                    |  |  |  |  |
|-----------------------------|--------------------|--|--|--|--|
| Usual Residence of Decedent |                    |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10a. State<br>Maryland      | 10b. County<br>N/A | 10c. City, Town or Location<br>Baltimore |  |  |  |

|  |                        |                                      |
|--|------------------------|--------------------------------------|
| 10e. Street and Number<br>5503 Bowleys Lane Apt 4D | 10f. Zip Code<br>21206 | 10g. Citizen of What Country?<br>USA |
|--|------------------------|--------------------------------------|

|  |  |   |   |
|--|--|---|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Black<br>Specify: |
|--|--|---|---|

|  |   |  |
|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th grade | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Housewife | 16b. Kind of Business/Industry<br>Own Home |
|--|---|--|

|  |   |
|--|---|
| 17. Father's Name (First, Middle, Last)<br>Rogers Murray | 18. Mother's Name (First, Middle, Maiden Surname)<br>Shirley A. Brice |
|--|---|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Shirley Crews | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4033 Shannon Drive Baltimore, MD 21213 |
|---|---|

|   |  |                |  |
|---|--|----------------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oaklawn Cemetery | Date<br>5/8/12 | 20c. Location - City or Town, State<br>Baltimore, MD |
|---|--|----------------|--|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br>Cullen Harris per dvr | 22. Name and Address of Facility<br>Chatman-Harris Funeral Home<br>4210 Belair Road Baltimore, MD 2121 |
|--|--|

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

|  |  |
|--|--|
| Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiac Arrhythmia<br>Due to (or as a consequence of): |  |
|--|--|

|   |  |
|---|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Air Embolism<br>Due to (or as a consequence of): |  |
|---|--|

|   |  |
|---|--|
| c. Complication of Placement of Central Venous Catheter<br>Due to (or as a consequence of): |  |
|---|--|

|    |  |
|----|--|
| d. |  |
|----|--|

|                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> UNPENDED | <input checked="" type="checkbox"/> AMENDED 21 per fh g927 5-24-12 vt |
|-----------------------------------|---|

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |   |  |
|---|---|--|
| hypertensive atherosclerotic cardiovascular disease | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|---|--|

|   |   |   |
|---|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|---|

|  |   |                                 |   |  |
|--|---|---------------------------------|---|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>May 1, 2012 | 28b. Time of Injury<br>1412 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>During placement of central venous catheter |
|--|---|---------------------------------|---|--|

|  |   |
|--|---|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Hospital | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Johns Hopkins Hospital, Baltimore, MD |
|--|---|

|  |   |                                 |  |
|--|---|---------------------------------|--|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br>Pamela E. Southall, MD | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 2, 2012 |
|--|---|---------------------------------|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |  |
|--|--|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012 | 32. Registrar's Signature<br>Lorraine L. Parker |
|--|---|

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

#2

1

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15069

1 - For  
State  
Registrar

|  |  |   |   |   |  |   |  |   |   |   |
|--|--|---|---|---|--|---|--|---|---|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>                         | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian McFarland</b>   |   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>2012</b>  | 3. Time of Death<br><b>8:58A M</b>   |   |   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>4319 Kennison Avenue</b>  |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  | 4c. County of Death<br><b>N/A</b>  |   |   |   |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>224-32-8683</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>101</b> Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 20, 1910</b>  | 9. Birthplace (State or Foreign Country)<br><b>S. Carolina</b>                                 |   |   |   |
| To Be Completed by Funeral Director                                | 10a. State <b>Maryland</b> 10b. County <b>N/A</b>  |   |   |   |  | 10c. City, Town or Location<br><b>Baltimore</b>   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |
|  | 10e. Street and Number<br><b>4319 Kennison Avenue</b>  |   |   | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>                                 |   |   |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>8th grade</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b> |   |  | 16b. Kind of Business/Industry<br><b>Private Family</b>   |  |   |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Titus Manning</b>  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Flora E. Bethaea</b>  |  |   |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise Parker/Daughter</b>  |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3500 Springfield Avenue Baltimore, Maryland 21216</b> |  |   |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gettysburg National Cem.</b>   |  | Date <b>5/14/12</b>   | 20c. Location - City or Town, State<br><b>Gettysburg, PA</b>                                   |   |   |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Shalini B. Boyapati</b>  |   |   | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home<br/>5240 Reisterstown Rd Baltimore, MD 21215</b>   |  |   |  |   |   |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>                         | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>myocardial infarction</b>   |   |   |   |  |   |  | Approximate Interval Between Onset and Death  |   |   |
|  | 23b. If female:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   |   |   |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year   |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>1) left Pleural effusion 2) left lung mass<br/>3) hypertension.</b>   |   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |   |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | 26. Place of Death (Check only one)                   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |   |   |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
|  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  | 29b. Signature and title of certifier<br><b>Shalini B. Boyapati MD</b>  | 29c. License number<br><b>D65616</b>  | 29d. Date signed (Month, Day, Year)<br><b>5/11/12</b> |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shalini Boyapati 2345 Belvedre Avenue, Suite 22, Baltimore MD.</b>  |   |   |   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   | 32. Registrar's Signature<br><b>Leanne J. Park</b>  |   |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15070

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1-

For  
State  
Registrar

|  |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Ann McHugh</b>  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> , Year <b>2012</b>  |   |  |  | 3. Time of Death<br><b>10:05 pm</b>                                     |  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Sunrise Assisted Living</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |   |  |  | 4c. County of Death<br><b>Montgomery</b>                                |  |   |  |
| 5. Social Security Number<br><b>186-30-9750</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 28, 1933</b>          | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                    |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Wicomico</b>  |   | 10c. City, Town or Location<br><b>Willards</b>  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>6325 Perdue Road</b>  |  |   |   | 10f. Zip Code<br><b>21874</b>   |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>5+</b>  |   | 16b. Kind of Business/Industry<br><b>Administrator</b>  |  |  | Education   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>James L. McHugh</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annette Dalton</b>  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Angela Stierhoff (Niece)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6325 Perdue Rd., Willards, MD 21874</b> |   |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Good Shepherd Cem.</b>   |   |   | Date<br><b>5/11/2012</b>   | 20c. Location - City or Town, State<br><b>Monroeville, PA</b>  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Metropolitan Funeral Service<br/>5517 Vine St., Alexandria, VA 22310</b>   |   |   |  |  |   |  |   |  |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Metastatic ovarian carcinoma</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death: <b>2 months</b></p>                        |  |   |   |   |  |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |   |  |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |   |   |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>assisted living</b>   |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |  |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DPhi61382</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>5/7/12</b>                                 |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shama R. Mittal, M.D. 4816 Physicians Lane, #142, Rockville, MD 20850</b>   |  |   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |   | 32. Registrar's Signature<br>   |   |  |  |   |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# SuperDVR, G927, 5/14/2012, WS

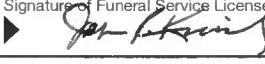
State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2012 15071

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| Physician/<br>Medical<br>Examiner                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Muriel Lockhart Maxwell</b><br>2. Date of Death<br>Month Day Year<br><b>May 8, 2012</b><br>3. Time of Death<br>3:00 PM   |  |  |  |   |  |   |  |
| Funeral<br>Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Renaissance Gardens</b><br>4b. City, Town, or Location of Death<br><b>Silver Spring</b><br>4c. County of Death<br><b>Prince George's</b>   |  |  |  |   |  |   |  |
| To Be Completed by Funeral Director                                |  | 5. Social Security Number<br><b>027-22-1234</b><br>6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F<br>7. Age (In yrs. last birthday)<br><b>83</b> Yrs.<br>If Under 1 Year      If Under 24 Hrs.<br>Months Days Hours Min.  |  |  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 23, 1928</b><br>9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 10a. State<br><b>Maryland</b><br>10b. County<br><b>Montgomery</b><br>10c. City, Town or Location<br><b>Silver Spring</b><br>10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>3122 Gracefield Road Apt. 612</b><br>10f. Zip Code<br><b>20904</b><br>10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced<br>12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>White</b>   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>12</b>   |  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b><br>16b. Kind of Business/Industry<br><b>Government Contractor (TASK)</b>  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Samuel Cassidy</b><br>19a. Informant's Name/Relationship (Type, Print)<br><b>Lois Anderson/ Niece</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rachel Johnstone</b><br>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1732 Peachtree Lane Bowie, MD 20721</b>   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Lakemont Memorial Gardens</b>   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakemont Memorial Gardens</b><br>Date<br><b>5/11/2012</b><br>20c. Location - City or Town, State<br><b>Davidsonville, MD</b>   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home</b><br><b>16000 Annapolis Road Bowie, MD 20715</b>  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Cancer (Primary Unknown)</b><br>Due to (or as a consequence of):<br>a. <b>Metastatic Cancer (Primary Unknown)</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Approximate Interval Between Onset and Death<br><b>2 Years</b> |  |  |  |   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><b>Hypertension</b>   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury</b><br><b>M</b><br><b>28c. Injury at work?</b><br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                  |  |  |  | 29c. License number<br><b>R1581067</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/2012</b>  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eileen Gemmell Renaissance Gardens Silver Spring, Md</b>   |  |  |  |   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br> |  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



State  
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15072

Reg. No.

|                                     |  |  |  |   |  |   |   |  |   |   |  |  |  |
|-------------------------------------|--|--|--|---|--|---|---|--|---|---|--|--|--|
| 1- For State Registrar              |  | 1. Decedent's Name (First, Middle, Last)<br><b>Ellen Yvonne Moss</b>   |  |   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 15, 2012</b>                  |   | 3. Time of Death<br><b>5:22 AM M</b>  |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>811 N. Central Avenue</b>   |  |   |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                     |   | 4c. County of Death   |  |  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>218-18-8661</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>87 Yrs.</b> | If Under 1 Year<br>Months   |   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec 31, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>MD</b>  |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  |   | 10d. Inside City Limits<br><b><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |  |
|                                     |  | 10e. Street and Number<br><b>811 N. Central Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21202</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>                   |   |  |  |  |
|                                     |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |  |   | 14. Race - American Indian, Black, White, etc.<br><b>black</b>  |  |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>  |  | 16b. Kind of Business/Industry<br><b>School system</b>  |   |  |   |   |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Clarence Bates</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ella Banks</b>   |   |  |   |   |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christy Moss/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>811 N. Central Avenue Baltimore, MD 21202</b>   |   |  |   |   |  |  |  |
|                                     |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>                          |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date   | 20c. Location - City or Town, State                           |   |  |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>  |   |  |   |   |  |  |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |   |  |   |   |  |   | Approximate Interval Between Onset and Death<br><b>7/2011 - 4/15/2012</b>   |  |  |  |
|                                     |  | <p>a. Due to (or as a consequence of):<br/><b>Malignant Thymoma Recurrence</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |  |   |  |   |   |  |   |   |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>              |  |   |   |  |   | 23d. Date of delivery<br>Month Day Year   |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |  |  |
|                                     |  |  |  |   |  |   |   |  |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |   |   |  |   |   |  |  |  |
|                                     |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  | 28d. Describe how injury occurred                             |   |  |  |  |
|                                     |  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  |   |  |   |   |  |   |   |  |  |  |
|                                     |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner</b>  |  | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                     |  |   |   |  |   |   |  |  |  |
|                                     |  | 29b. Signature and title of certifier<br><b>Ann Lee CRNP</b>   |  | 29c. License number<br><b>RO72044</b>   |  |   |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>4/24/2012</b>   |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ann Lee CRNP EBMC 1000 E. Eager St. Balt MD 21202</b>   |  |   |  |   |   |  |   |   |  |  |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Laura J. Pace</b>   |  |   |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 19a, per Ana Bd, g927 5-11-12 sm

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15073

1 - For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William J. Miller Sr

2. Date of Death

Month May Day 4 Year 2012

3. Time of Death

11:15 A M

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Miller, William Joseph Sr.  
Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

|  |             |  |                                      |                 |      |                               |      |
|--|-------------|--|--------------------------------------|-----------------|------|-------------------------------|------|
| 1. Decedent's Name (First, Middle, Last)                       |             |  | 2. Date of Death                     |                 |      |                               |      |
| William J. Miller Sr   |             |  | Month May Day 4 Year 2012            |                 |      |                               |      |
| 4a. Facility Name (if not institution, give street and number) |             |  | 4b. City, Town, or Location of Death |                 |      |                               |      |
| Saint Joseph Medical Center                                    |             |  | TOWSON                               |                 |      |                               |      |
| 5. Social Security Number                                      |             | 6. Sex   | 7. Age (In yrs. last birthday)       | If Under 1 Year |      | If Under 24 Hrs.              |      |
| 217-26-3602  |             | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 81 Yrs.                              | Months          | Days | Hours                         | Min. |
| Usual Residence of Decedent                                    |             |  |                                      |                 |      |                               |      |
| 10a. State   | 10b. County | 10c. City, Town or Location  |                                      |                 |      |                               |      |
| MD   | Baltimore   | Timonium   |                                      |                 |      |                               |      |
| 10e. Street and Number   |             |  | 10f. Zip Code                        |                 |      | 10g. Citizen of What Country? |      |
| 2525 Pot Spring Riad #5305                                     |             |  | 21093                                |                 |      | USA                           |      |

|   |                                    |   |   |  |                                     |  |  |
|---|------------------------------------|---|---|--|-------------------------------------|--|--|
| 11. Marital Status  |                                    | 12. Was Decedent Ever in U.S. Armed Forces? |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     | 14. Race - American Indian, Black, White, etc. |  |
| 1 <input type="checkbox"/> Never Married                        | 2 <input type="checkbox"/> Married | 1 <input checked="" type="checkbox"/> Yes   | 2 <input type="checkbox"/> No   | 3 <input checked="" type="checkbox"/> Widowed  | 4 <input type="checkbox"/> Divorced | 1 <input type="checkbox"/> Yes                 | 2 <input checked="" type="checkbox"/> No |
|   |                                    | If Yes, Give Year or Dates.                 |   | '52-58   |                                     | Specify: white                                 |  |
| 15. Decedent's Education (Specify only highest grade completed) |                                    |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |                                     | 16b. Kind of Business/Industry                 |  |
| Elementary/Secondary (0-12) 12                                  |                                    |   | College (1-4 or 5+) 0   |  |                                     | electrical designer                            |  |

|  |  |  |   |  |      |                                     |  |
|--|--|--|---|--|------|-------------------------------------|--|
| 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |  |      |                                     |  |
| Anthony Albert Miller Sr   |  |  | Catherine Ford  |  |      |                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |      |                                     |  |
| Susan Miller/daughter  |  |  | 37 Stoneway Place Baltimore, MD 21236   |  |      |                                     |  |
| 20a. Method of Disposition   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                        |  | Date | 20c. Location - City or Town, State |  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |   |  |      |                                     |  |

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 21. Signature of Funeral Service Licensee |  | 22. Name and Address of Facility                                |  |  |  |  |  |
| Ronald S. Wade, Director                  |  | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |  |  |  |  |  |

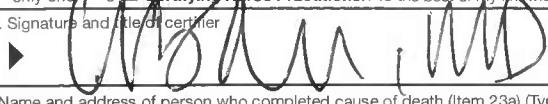
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |  |  |  |  |  |  |
| Chronic Obstructive Pulmonary Disease with Exacerbation 10days  |  |  |  |  |  |  |  |
| a. Due to (or as a consequence of):   |  |  |  |  |  |  |  |
| Severe Esophagitis with Upper GI Bleed 10days   |  |  |  |  |  |  |  |
| b. Due to (or as a consequence of):   |  |  |  |  |  |  |  |
| c. Due to (or as a consequence of):   |  |  |  |  |  |  |  |
| d. Due to (or as a consequence of):   |  |  |  |  |  |  |  |

|  |  |  |  |  |                       |      |     |
|--|--|--|--|--|-----------------------|------|-----|
| IF FEMALE:   |  | 23c. If yes, outcome of pregnancy                    |  |  |                       |      |     |
| 23b. Was decedent pregnant in the past 12 months?            |  | 1 <input type="checkbox"/> Live Birth                | 2 <input type="checkbox"/> Fetal death           | 3 <input type="checkbox"/> Ectopic pregnancy | 23d. Date of delivery |      |     |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 4 <input type="checkbox"/> Pregnant at time of death | 5 <input type="checkbox"/> Other (specify) _____ | Month  |                       |      | Day |
| 9 <input type="checkbox"/> Unknown                           |  | 9 <input type="checkbox"/> Unknown                   |  |  |                       | Year |     |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                         |  |  |  |  |  |  |  |
| Diabetes Mellitus  |  |  |  |  |  |  |  |
| Atrial Fibrillation / Rapid Ventricular Response   |  |  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?   |  |  |  |  |  |  |  |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |  |  |  |  |

|  |  |  |  |  |  |                                   |  |
|--|--|--|--|--|--|-----------------------------------|--|
| 25. Was case referred to medical examiner?   |  | 26. Place of Death (Check only one)  |  |  |  |                                   |  |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |                                   |  |
| 27. Manner of Death  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury  | 28c. Injury at work?   | 28d. Describe how injury occurred |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined |  |  |  | M  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                   |  |
| 3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|

|   |  |                     |  |                                     |  |  |  |
|---|--|---------------------|--|-------------------------------------|--|--|--|
| 29b. Signature and title of certifier   |  | 29c. License number |  | 29d. Date signed (Month, Day, Year) |  |  |  |
|  |  | D35453              |  | 5/4/12                              |  |  |  |

|  |   |  |  |
|--|---|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |   |  |  |
| Linda Barr, M.D. 7505 Osler Drive, Suite 409 TOWSON, MD 21204                        |   |  |  |
| 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature   |  |  |
| MAY 11 2012  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amend 24a, 26 per dr. g927 Certificate of Death

Reg. No. 2012 15074

|   |  |  |   |  |  |   |   |                                     |
|---|--|--|---|--|--|---|---|-------------------------------------|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Carter Immanuel McGee</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 16, 2012</b>                      | 3. Time of Death<br>11:59 PM  |   |                                     |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Southern Maryland Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince George's</b>                                    |   |   |                                     |
| Funeral<br>Director   | 5. Social Security Number<br><b>infant</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.<br>Months Days Hours Min.  | If Under 1 Year<br>Months<br>2   | If Under 24 Hrs.<br>Hours<br>2   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Apr 16, 2012</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                     |
|   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Cheltenham</b>                                 |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                     |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>10713 Heather Leigh Drive</b>   |  |   | 10f. Zip Code<br><b>20623</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |                                     |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.    |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                     |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>infant</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>infant</b> |  |   | 16b. Kind of Business/Industry<br><b>infant</b>   |                                     |
|   | 17. Father's Name (First, Middle, Last)<br><b>/Dondrae L. McGee</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Veronica D. McGee</b>  |  |   |   |                                     |
| Physician/<br>Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Souther Maryland Hospital Ctr</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7503 Surratts Road Clinton, MD 20735</b>         |  |   |   |                                     |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>                        |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  |   | Date  | 20c. Location - City or Town, State |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade Director</b>  |  |   | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>   |  |   |   |                                     |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |   | 23b. Part 2. Enter the underlying cause (disease or injury that initiated events resulting in death). Last   |  |   | Approximate Interval Between Onset and Death  |                                     |
| <p>a. <b>Severe prematurity</b><br/>Due to (or as a consequence of):</p> <p>b. <b>premature labor</b><br/>Due to (or as a consequence of):</p> <p>c. <b></b><br/>Due to (or as a consequence of):</p> <p>d. <b></b><br/>Due to (or as a consequence of):</p>  |  |  |   |  |  |   |   |                                     |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |   |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                     |
|   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                     |
|   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |  |  |   |   |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |   |                                     |
|   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                     |
| 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |   |                                     |
| 29b. Signature and title of certifier<br><b>James Vitek, pediatrician</b>   |  |  | 29c. License number<br><b>D 0044492</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>04/11/2012</b>  |   |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Vitek, 7503 Surratts Road, Clinton, Maryland, 20735</b>  |  |  |   |  |  |   |   |                                     |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Ronald S. Wade</b>                         |   |  |  |   |   |                                     |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For item 1 and 2 should be filed within 72 hours after death with the Maryland  
Attendant of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
the time of death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15075

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |
|---|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>CAMERON TAEWON PARK MOULTON</b>  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>9</b> , Year <b>2012</b>  |  | 3. Time of Death<br><b>01:30AM</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>4326 JORDAN WAY</b>  |  | 4b. City, Town, or Location of Death<br><b>PERRY HALL</b>   |  | 4c. County of Death<br><b>BALTO.</b>  |
| 5. Social Security Number<br><b>N/A</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs.<br><b>2</b> <b>6</b>                            | If Under 1 Year<br>Months <b>2</b> Days <b>6</b> Hours <b>0</b> Min. <b>0</b>   |
| 8. Date of Birth<br>(Month Day Year)<br><b>3-3-2012</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTO.</b>  |  | 10c. City, Town or Location<br><b>PERRY HALL</b>  |
| 10e. Street and Number<br><b>4326 JORDAN WAY</b>  |  | 10f. Zip Code<br><b>21128</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>BI-RACIAL</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) N/A</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) N/A</b>  |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>NATHAN MOULTON</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LINDA PARK</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LINDA MOULTON MOTHER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4326 JORDAN WAY PERRY HALL, MD. 21128</b>   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>ATLANTIC CREMATORY</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ATLANTIC CREMATORY</b>   |  | Date <b>5-11-2012</b> 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>  |
| 21. Signature of Funeral Service Licensee<br><b>► Debra Rineker</b>   |  | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME, INC<br/>9705 BELAIR ROAD NOTTINGHAM, MD. 21236</b>   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)                            |  | Approximate Interval Between Onset and Death  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown<br><b>SPINAL MUSCULAR ATROPHY</b>   |  | 23d. Date of delivery<br>Month Day Year   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 23f. Did alcohol contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><b>1</b> |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   |  | 28d. Describe how injury occurred   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>037130</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THOMAS O CRAWFORD, Johns Hopkins Hospital, 700 N. Wolfe Street</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>James J. Parker</b>   |

Division of Vital Records, P.O. Box 68760  
Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend Items 20b,c per fh g928 6-8-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15076

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death   |  | 3. Time of Death   |  |
| HELEN ANITA MOSBERG  |  | Month<br>May<br>Day<br>3<br>Year<br>2012   |  | 9:29 P M   |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death  |  |
| Siuri Hosptl of Baltimore  |  | Baltimore City   |  |  |  |
| 5. Social Security Number  |  | 6. Sex   |  | 7. Age (In yrs. last birthday)   |  |
| 216-42-9571  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 66 Yrs.  |  |
| Usual Residence of Decedent  |  | If Under 1 Year<br>Months  |  | If Under 24 Hrs.<br>Hours  |  |
|  |  |  |  | Min.   |  |
| 10a. State   |  | 10b. County  |  | 10c. City, Town or Location  |  |
| MD.  |  |  |  | BALTIMORE  |  |
| 10e. Street and Number   |  | 10f. Zip Code  |  | 10g. Citizen of What Country?  |  |
| 4003 WHITE AVENUE APT C1   |  | 21206  |  | USA  |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business/Industry   |  |
| Elementary/Secondary (0-12) 12   |  | College (1-4 or 5+) 8  |  | OCTAVIA'S DRESS SHOP   |  |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |  |  |
| WILSON N. MOSBERG  |  | RACHEL E. WALLACE  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |
| EVELYN M. KIMOS SISTER   |  | 4003 WHITE AVENUE APT.C1 BALTO. MD. 21206  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of<br>UNKNOWM<br>Category or other place)<br>Baltimore National  |  | Date<br>UNKNOWN<br>6-5-12  | 20c. Location - City or Town, State<br>UNKNOWN<br>Catonsville, Md.                   |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility   |  | MILLER-DIPPEL FUNERAL HOME, INC.<br>6415 BELAIR ROAD BALTO. MD. 21206  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Acute Myocardial Infarction  |  | Approximate Interval Between Onset and Death<br>5 days   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D0063298  |  | 29d. Date signed (Month, Day, Year)<br>May 3, 2012   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  | 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>Suzanne J. Parker   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15077

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

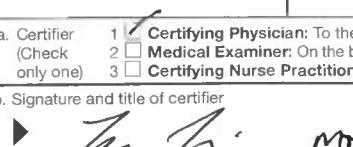
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760

|  |  |   |                    |   |   |  |   |  |   |  |
|--|--|---|--------------------|---|---|--|---|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>John V. Musacchio Sr.</b>  |                    |   |   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>1</b> Year <b>2012</b>           | 3. Time of Death<br><b>3:10 AM</b>  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Union Memorial Hospital</b>  |                    |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |   | 4c. County of Death  |   |  |
|  |  | 5. Social Security Number<br><b>unk</b>   | 6. Sex<br><b>M</b> | 7. Age (In yrs. last birthday)<br><b>56</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>05/13/1955</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                        |   |  |
|  |  | 10a. State<br><b>MD</b>   |                    | 10b. County   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><b>X</b> Yes <b>2</b> No   |  |
|  |  | 10e. Street and Number<br><b>1019 W 37th Street</b>   |                    |   | 10f. Zip Code<br><b>21211</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>                                  |   |  |
|  |  | 11. Marital Status<br><b>X</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |                    | 12. Was Decedent Ever in U.S. Armed Forces<br><b>X</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b><br>Specify:   |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12yrs</b>  |                    |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>  |  |   | 16b. Kind of Business/Industry<br><b>Home Improvement</b>                    |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>John Musacchio</b>  |                    |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ann Murphy</b>  |  |   |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Musacchio Jr Son</b>  |                    |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3904 4th Street Baltimore MD 21225</b>  |  |   |  |   |  |
|  |  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crem</b>  |  |   | Date<br><b>5/02/12</b>   | 20c. Location - City or Town, State<br><b>Glen Burnie MD</b>  |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  |                    |   | 22. Name and Address of Facility<br><b>Simplicity Crem &amp; Fun Serv</b><br><b>ThomasAllenPA 7090 Ridge Rd Hanover MD</b>  |  |   |  |   |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)  |                    |   | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Due to (or as a consequence of):<br><br><b>Locked - In Syndrome.</b> |  |   | Approximate Interval Between Onset and Death                                 |   |  |
|  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                    |   | 23c. If yes, outcome of pregnancy<br><b>1</b> Live Birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify) _____<br><b>9</b> Unknown   |  |   |  |   |  |
|  |  | 23d. Date of delivery<br>Month Day Year   |                    |   |   |  |   |  |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                    |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |   |  |   |  |
|  |  |   |                    |   |   |  |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |
|  |  | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |                    |   | 26. Place of Death (Check only one)<br>Hospital:<br><b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br><b>Other:</b> <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)   |  |   |  |   |  |
|  |  | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>7</b> Homicide<br><b>4</b> Homicide   |                    |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1</b> Yes <b>2</b> No            | 28d. Describe how injury occurred  |   |  |
|  |  |   |                    |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
|  |  | 29a. Certifier<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3</b> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                    |   | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>AT2438946</b>                                      | 29d. Date signed (Month, Day, Year)<br><b>May 1, 2012</b>   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ty Lai, Union Memorial Hospital, 201 E. University PKwy, Baltimore MD 21218</b>  |                    |   |   |  |   |  |   |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |                    |   | 32. Registrar/Signatur<br>   |  |   |  |   |  |

ORIGINAL

2012 15078

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| Physician/<br>Medical Examiner                |  | 1. Decedent's Name (First, Middle, Last)<br><b>David Christopher Norris</b>  |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>May 6, 2012                       | 3. Time of Death<br>1616 hrs   |
| Funeral Director                              |  | 4a. Facility Name (if not institution, give street and number)<br>Prince George's Hospital Center  |  |   | 4b. City, Town, or Location of Death<br>Cheverly   |   |  | 4c. County of Death<br>Prince George's                                  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>213-21-8296</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>31</b><br>Yrs.  |   | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth (MM/DD/YYYY)<br><b>08/28/1980</b>  | 9. Birthplace (State or Foreign Country)<br><b>Wash. D.C.</b>           |  |
|   |  | Usual Residence of Decedent<br><b>MD.</b>  |  | 10b. County<br><b>P.G.</b>  |  | 10c. City, Town or Location<br><b>Upper Marlboro</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 10e. Street and Number<br><b>4825 King John Way</b>  |  |   | 10f. Zip Code<br><b>20772</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Realtor</b>                              |   |  | 16b. Kind of Business/Industry<br><b>Private</b>                        |  |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Douglas M. Norris</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olga Johnson</b>   |   |  |   |  |
|   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Olga Johnson/Mother</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1717 Whistling Duck Dr. Upper Marlboro Md. 20774</b> |   |  |   |  |
| Physician<br>Medical<br>Examiner              |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:<br><i>Jyelt W. Hackett Jr.</i>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Heritage Memorial</b>  |  | Date<br><b>5/18/12</b>  | 20c. Location - City or Town, State<br><b>Waldorf, Md.</b>   |   |  |
|   |  | 21. Signature of Funeral Service Licensee<br><i>Jyelt W. Hackett Jr.</i>   |  | 22. Name and Address of Facility<br><b>Hackett's Funeral Chapel, Inc. 814 Upshur Street, N.W. DC 20011</b>  |  |   |  |   |  |
|   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. Multiple Injuries<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.  |  |   | Approximate Interval Between Onset and Death   |   |  |
|   |  | <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |  |   |  |   |  |   |  |
|   |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |
|   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other                  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: May 6, 2012</b>   | 28b. Time of Injury<br><b>FOUND: 1510 hrs</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred<br><b>Operator of motorcycle that struck a fixed object</b>  |   |  |
|   |  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>Local Street</b>   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Brown Station Road and Brooks Road, Upper Marlboro,</b>   |   |  |
|   |  | 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b>  |   |  |
|   |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |   |  |   |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |   |  |

**Division of Vital Records, P.O. Box 68760,**  
**or Attending Physician:** The law requires that the death certificate be executed

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

**Baltimore, MD 21215-0036**

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23 or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15079

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1203 hrs |
| Lynn S. North                            | April 28, 2012                     |                              |

**Funeral Director**

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 4a. Facility Name (if not institution, give street and number)<br>6606 Rapid Water Way Apt. #101 | 4b. City, Town, or Location of Death<br>Glen Burnie                            | 4c. County of Death<br>Anne Arundel       |   |   |  |
| 5. Social Security Number<br>142-44-4854   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>59 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>07/29/1952 | 9. Birthplace (State or Foreign Country) Unknown |

|                             |                             |  |  |  |  |
|-----------------------------|-----------------------------|--|--|--|--|
| Usual Residence of Decedent |                             |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10a. State<br>Maryland      | 10b. County<br>Anne Arundel | 10c. City, Town or Location<br>Glen Burnie |  |  |  |

|   |                        |   |
|---|------------------------|---|
| 10e. Street and Number<br>6606 Rapid Water Way Apt. 101 | 10f. Zip Code<br>21060 | 10g. Citizen of What Country?<br>U.S.A. |
|---|------------------------|---|

|   |  |   |  |
|---|--|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>Specify: White | 14. Race - American Indian, Black, White, etc. |
| 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced If Yes, Give Year or Dates: |  |   |  |

|  |   |   |
|--|---|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>4 | 16b. Kind of Business/Industry<br>Teacher |
|--|---|---|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>Unknown | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown |
|--|--|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>James H. Mason (Guardian) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>600 Baltimore-Annapolis Blvd. Suite 200 Severna Park, MD 21146 |
|---|---|

|   |  |                    |  |
|---|--|--------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Atlantic Cremation | Date<br>05/09/2012 | 20c. Location - City or Town, State<br>Glen Burnie, Maryland |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  |                    |  |

|  |         |  |
|--|---------|--|
| 21. Signature of Funeral Service Licensee<br><i>J.H. Mason</i> | MOO-732 | 22. Name and Address of Facility<br>McCullly-Poliomyak Funeral Home, P.A.<br>3204 Mountain Road Pasadena, Maryland 21122 |
|--|---------|--|

**Baltimore, MD 21215-0036**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician/  
Medical Examiner**

|  |  |  |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | a <b>Acute Pancreatitis complicating Hypertrophic Cardiomyopathy</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|--|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
| c.<br>Due to (or as a consequence of):   |  |  |
| d.<br>Due to (or as a consequence of):   |  |  |

|  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g928 6-21-12 sm |  |
|--|---|--|

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Insufficiency</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|--|

|  |  |  |  |                                   |
|--|--|--|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |

|   |  |  |  |
|---|--|--|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
|---|--|--|--|

|  |                                 |   |
|--|---------------------------------|---|
| 29b. Signature and title of certifier<br><i>Ana Rubio MD</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>April 29, 2012 |
|--|---------------------------------|---|

|   |  |  |
|---|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | 31. Date filed (Month, Day, Year)<br>MAY 11 2012 | 32. Registrar's Signature<br><i>Leanne S. Parker</i> |
|---|--|--|

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For Amend Items 20b,c,22 per Th, g927,05/14/2012dhb  
State of Maryland / Department of Health and Mental Hygiene  
1- State Registrar Certificate of Death Reg. No. 2012 15080

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)   |   |  |  | 2. Date of Death<br>Month Day Year   | 3. Time of Death   |
|  | Queenie Owens  |   |  |  | May 1 2012   | 1308 M   |
| <b>Funeral<br/>Director</b>  | 4a. Facility Name (if not institution, give street and number)<br>The Johns Hopkins Hospital   |   |  | 4b. City, Town, or Location of Death<br>Baltimore City                           |  | 4c. County of Death  |
|  | Social Security Number<br>255-36-6258  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs.  | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>June 4, 1926   | 9. Birthplace (State or Foreign Country)<br>South Carolina                                     |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br>MD   | 10b. County   | 10c. City, Town or Location<br>Baltimore   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br>524 N. Charles Street #618   |   |  | 10f. Zip Code<br>21201   |  | 10g. Citizen of What Country?<br>USA   |
| <b>To Be Completed by Funeral Director</b>   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: black                               |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6  | College (1-4 or 5+) 0   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>actress                      |  |  | 16b. Kind of Business/Industry<br>entertainment  |
| 17. Father's Name (First, Middle, Last)<br>Sydney Owens  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Charity Bunch               |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lynette Gibson/niece   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10134 Deep Creek Drive Union City, GA 30291 |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>On-Site Cremetory   |  | Date<br>05/13/2012   | 20c. Location - City or Town, State<br>Baltimore, MD   |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director  |  | 22. Name and Address of Facility<br>State Anatomy Board 655 W Baltimore Street<br>John L. Williams Funeral Directors, 4517 Park Heights Ave.<br>Baltimore, MD 21201 21215   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br>a. Atherosclerotic cardiovascular disease<br>Due to (or as a consequence of):   |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | {<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  | 23f. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Asa Margolis   |  |  |  |  |
|  |  | 29c. License number<br>RES-800  |  |  | 29d. Date signed (Month, Day, Year)<br>May 2, 2012   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Asa Margolis   |  | 1800 Orleans St. Baltimore MD 21237   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>Leanne J. Parker   |  |  |  |  |

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

3

State  
Registrar

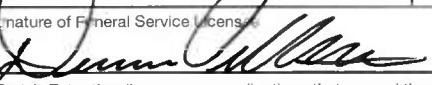
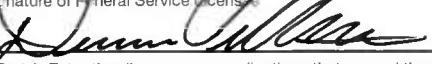
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15081

**1 - For State Registrar**

|   |  |  |  |   |  |  |  |   |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Barbara A. Ott</b>  |  |   |  |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>8</b> , Year <b>2012</b>  |   | 3. Time of Death<br><b>7:00 A M</b>                          |  |  |  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>Carriage Hill</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  |  | 4c. County of Death<br><b>Montgomery</b>  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>204-22-8764</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/>   | If Under 24 Hrs.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>  | 8. Date of Birth<br>Month <b>Dec.</b> Day <b>29</b> , Year <b>1931</b>                    |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>5215 Cedar Lane</b>   |  |   |  | 10f. Zip Code<br><b>20814</b>  |  |   | 10g. Citizen of What Country?<br><b>White</b>   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |   |   | 14. Race - American Indian, Black, White, etc.               |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Person</b>                      |  |   | 16b. Kind of Business/Industry<br><b>Keebler Food</b>                                     |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>James Tuck</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Dugan</b>  |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Ott (Son)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5160 Las Verdes Cir. #301 Delray Beach, FL 33484</b> |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metroopolitan Crematory</b>   |  |   | Date<br><b>5/9/2012</b>   | 20c. Location - City or Town, State<br><b>Alexandria, VA</b> |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Metropolitan Funeral Service</b><br><b>5517 Vine St., Alexandria, VA 22310</b>                                    |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  | <b>Aspiration Pneumonia</b>  |  |   | Approximate Interval Between Onset and Death  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | b.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  | <b>Dysphagia</b>   |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | c.<br><b>Alzheimer's Disease</b>   |  |   |  | Due to (or as a consequence of):   |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | d.<br><b></b>  |  |   |  | Due to (or as a consequence of):   |  |   |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |   | 23d. Date of delivery<br>Month <input type="checkbox"/> Day <input type="checkbox"/> Year |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  |   | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No      |  | 28d. Describe how injury occurred  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  | 29b. Signature and title of certifier<br>  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |  |  |  | 29c. License number<br><b>D35579</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>05/08/2012</b>                                       |  |  |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |   | 32. Registrar's Signature<br> |  |  |   |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15082

3. Time of Death  
1:20 AM

1 - For  
State  
Registrar

|                                     |  |  |   |  |  |  |  |   |  |
|-------------------------------------|--|--|---|--|--|--|--|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elfie Lurline Phillips</b>  |  |   |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 5, 2012</b>                | 3. Time of Death<br>1:20 AM  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>1641 Defense Highway</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Gambrills</b>   |  |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>220-16-4400</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 4, 1914</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>        |  |
|                                     | Usual Residence of Decedent<br><b>Maryland Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Gambrills</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br><b>1641 Defense Highway</b>  |  |   |  | 10f. Zip Code<br><b>21054</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>11</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Charles W. Cox</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary J. Bragg</b>  |  |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary O'Dell/ Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1641 Defense Highway Gambrills, MD 21054</b>   |  |  |   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br>   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Park</b>   |  |  | Date<br><b>5/8/2012</b>   |  |
|                                     |  |  |   |  |  |  |  | 20c. Location - City or Town, State<br><b>Annapolis, MD</b>             |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>16000 Annapolis Road Bowie, MD 20715</b>  |  |  |   |  |
|                                     |  |  |   |  |  |  |  | <b>Robert E. Evans Funeral Home</b>                                     |  |
| Physician<br>Medical<br>Examiner    | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>10 Years</b>  |
|                                     | a. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Peripheral Vascular Disease</b>  |  |   |  |  |  |  |   |  |
|                                     | b. Due to (or as a consequence of):<br><br><b>Hypertension</b>   |  |   |  |  |  |  |   |  |
|                                     | c. Due to (or as a consequence of):<br><br>d.  |  |   |  |  |  |  |   |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |  |  |  |   | 23d. Date of delivery<br>Month Day Year  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                     |  |  |   |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|                                     |  |  |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  |  |  |  |   | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury                              | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |   |  |
|                                     |  |  |   |  |  |  |  |   |  |
|                                     |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
|                                     | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0018480</b>  |  |  |  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5/7/2012</b>   |
|                                     | 29b. Signature and title of certifier<br>   |  |   |  |  |  |  |   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ronald Sroka, M.D. 1684 Village Green Crofton, MD 21114</b>   |  |   |  |  |  |  |   |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

6  
✓ DHMH 17 Rev 06-2011

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15083

1 - For  
State  
Registrar

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM PORTER</b>  |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>8</b> Year <b>2012</b> | 3. Time of Death<br><b>1031 A M</b>   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>        |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |   | 4c. County of Death  |   |   |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>225-56-6606</b>  | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>70 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.                                | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 29, 1941</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br><b>Virginia</b>  | 10b. County<br><b>Accomack</b>  | 10c. City, Town or Location<br><b>Sanford</b>   |   |  |   | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>            |
|  | 10e. Street and Number<br><b>23499 Saxis Road</b>  |   | 10f. Zip Code<br><b>23426</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>              |   |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 11. Marital Status<br><b>1 □ Never Married 2 X Married</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No</b><br>If Yes, Give Year or Dates.<br><b>1960-1966</b>                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No</b> Specify:<br><b>White</b> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                        |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b> |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Security</b>                                   |   |  | 16b. Kind of Business/Industry<br><b>Government</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Joseph Porter, Sr.</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Linton</b>  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eva Porter, Wife</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23499 Saxis Road, Sanford, VA 23426</b> |  |   |   |
| 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Downing's Cemetery</b>   |   | Date<br><b>05/10/2012</b>  | 20c. Location - City or Town, State<br><b>Oak Hall, Virginia</b>                                  |   |
| 21. Signature of Funeral Service Licensee<br><b>► TSM</b>  |  |   |   | 22. Name and Address of Facility<br><b>Harman Funeral Service, PA<br/>7221 Grayburn Drive, Glen Burnie, MD 21061</b>                        |  |   |   |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <u>Cardiac Arrhythmia</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Coronary Artery Disease</u><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> |  |   |   |   |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No 9 □ Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown |   |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 □ Yes 2 X No  |   |
|  |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 □ No     |   |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   |  | Hospital:<br>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA  |   | Other:<br>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)  |  | 26. Place of Death (Check only one)   |   |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 □ Yes 2 □ No                             | 28d. Describe how injury occurred   |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier<br>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |   |   |
| 29b. Signature and title of certifier<br><b>► W</b>  |  |   |   | 29c. License number<br><b>RES 000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 8 2012</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wan-Tsu Chang 1800 ORLEANS ST BALTIMORE MD 21287</b>  |  |   |   |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |   |   | 32. Registrar's Signature<br><b>James S. Parker</b>   |  |   |   |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

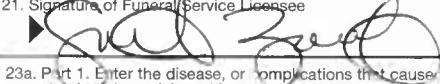
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15084

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                     |  |  |  |   |   |  |   |   |  |   |   |  |  |  |  |
|---------------------|--|--|--|---|---|--|---|---|--|---|---|--|--|--|--|
|                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>BERNICE CATHERINE POJUNAS</b>   |  |   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 10, 2012</b>   |  | 3. Time of Death<br>0129 M                                    |   |  |  |  |  |
|                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>UPPER CHESAPEAKE</b>  |  |   |   |  |   | 4b. City, Town, or Location of Death<br><b>BEL AIR</b>  |  | 4c. County of Death<br><b>HARFORD</b>                         |   |  |  |  |  |
| Funeral<br>Director |  | 5. Social Security Number<br><b>213-20-9891</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>87 Yrs.</b> |   | If Under 1 Year<br>Months Days Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>1-30-1925</b>    |   |  |  |  |  |
|                     |  | Usual Residence of Decedent<br><b>MD.</b>  |  | 10b. County<br><b>HARFORD</b>   |   | 10c. City, Town or Location<br><b>BEL AIR</b>    |   |   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   |  |  |  |  |
|                     |  | 10e. Street and Number<br><b>128 RING FACTORY ROAD</b>   |  |   |   |  |   | 10f. Zip Code<br><b>21014</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                   |   |  |  |  |  |
|                     |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |  |  |
|                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   |   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 6 TEACHER</b>  |  |   | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY PUBLIC SCHOOLS</b>  |  |  |  |  |
|                     |  | 17. Father's Name (First, Middle, Last)<br><b>EDWIN F. KNELL, SR.</b>  |  |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDNA C. LAUER</b>   |  |   |   |  |  |  |  |
|                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>RONALD POJUNAS SON</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1509 WILLOWDALE AVENUE BEL AIR, MD. 21015</b> |  |   |   |  |   |   |  |  |  |  |
|                     |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LAKEVIEW</b>   |  |   | Date<br><b>5-12-2012</b>  |  | 20c. Location - City or Town, State<br><b>SYKESVILLE, MD.</b> |   |  |  |  |  |
|                     |  | 21. Signature of Funeral Service Licensee<br>   |  |   |   |  |   | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME, INC.</b><br><b>610 W. MACPHAIL ROAD BEL AIR, MD. 21014</b>   |  |   |   |  |  |  |  |
|                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Myocardial infarction</b><br>Due to (or as a consequence of):<br><br>b. <b>Pulmonary edema</b><br>Due to (or as a consequence of):<br><br>c. <b>Incarcerated incisional hernia</b><br>Due to (or as a consequence of):<br><br>d.   |  |   |   |  |   |   |  |   |   |  |  |  |  |
|                     |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   | Approximate Interval Between Onset and Death  |  |   |   |  |  |  |  |
|                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year |   |  |   |   |  |  |  |  |
|                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>None</b>  |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |  |  |
|                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |  |
|                     |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury                              |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                             |   |  |  |  |  |
|                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |  |
|                     |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>Doc#5532</b>  |   |  |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>05/10/12</b>        |   |  |  |  |  |
|                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Geoffrey Bloomfield 520 Upper Chesapeake Drive Bel Air MD 21014</b>   |  |   |   |  |   |   |  |   |   |  |  |  |  |
| State<br>Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |   |   |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

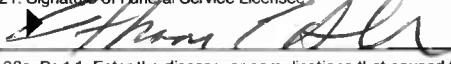
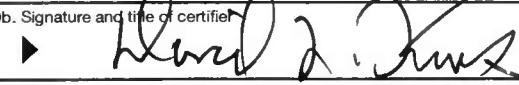
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15085

1- For  
State  
Registrar

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>George Paniker</b>  |  |  |  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>04/27/2012</b>    | 3. Time of Death<br>8:10pm M  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Joseph Richey Hospice</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   |  | 4c. County of Death  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-68-3467</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65</b><br>Yrs.  | If Under 1 Year<br>Months<br><b>0</b>  | If Under 24 Hrs.<br>Days<br><b>0</b>   | Hours<br><b>0</b>   | Min.<br><b>0</b>   | 8. Date of Birth<br>Month Day Year<br><b>05/20/1946</b>    | 9. Birthplace (State or Foreign Country)<br><b>India</b>  |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  | 10b. County  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>3101 Guilford Ave</b>   |  |  |  | 10f. Zip Code<br><b>21218</b>  |   |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Indian</b>  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>   |   |  |  | 16b. Kind of Business/Industry<br><b>Restaurants</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas Paniker</b>   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kunjamma</b>                          |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>George Xavier Nephew</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>304 Landers Court Exton PA 19341</b>   |   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral</b> |  |   | Date<br><b>5/5/2012</b>                                      | 20c. Location - City or Town, State<br><b>Baltimore MD</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility <b>Simplicity Crem &amp; Fun Serv</b><br>Thomas Allen P.A. 7090 Ridge Rd Hanover MD   |   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic Cancer</b>   |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |  |  |
|  | b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):  |  |  |  |  |   |  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown                     |  |  |   |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |  |  |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  |  |  |  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |   |  |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                          |   |  |  |
|  |  |  |  |  |  |   |  |  |   |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>DO6030</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 28, 2012</b> |  |   |  |  |
|  |  |  |  |  |  |   |  |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David L. Knox, 9 W. Lake Ave, Baltimore MD 21210-1303</b>   |  |  |  |  |   |  |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |  |  |

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15086

**1. For State Registrar**

|  |  |  |  |                                    |                              |
|--|--|--|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) |  |  |  | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>0713 hrs |
| Quintin Lee Poindexter                   |  |  |  | May 4, 2012                        |                              |

Physician/  
Medical Examiner

Funeral Director

**To Be Completed by Funeral Director****Physician / Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, MD 21215-0036**  
 Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 23a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**1. For State Registrar**

|  |  |  |  |                                    |                              |
|--|--|--|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) |  |  |  | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>0713 hrs |
| Quintin Lee Poindexter                   |  |  |  | May 4, 2012                        |                              |

Physician/  
Medical Examiner

Funeral Director

**To Be Completed by Funeral Director****Physician / Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 26 per doc 927 5-11-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15087

1 - For  
State  
Registrar

|  |   |  |   |  |  |  |   |   |  |
|--|---|--|---|--|--|--|---|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><i>Celestine Rose</i>   |  |   |  | 2. Date of Death<br>Month <u>MAY</u> Day <u>8</u> Year <u>2012</u>   | 3. Time of Death<br><u>2:30 PM</u>   |   |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><i>3909 Duvall Avenue</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |  | 4c. County of Death   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>215-18-5918</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>94</i> Yrs. | If Under 1 Year<br>Months    Days    Hours    Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>6/14/1917</i>                       | 9. Birthplace (State or Foreign Country)<br><i>South Carolina</i> |   |  |
|  | Usual Residence of Decedent   |  | 10a. State<br><i>MD</i>   |  | 10b. County<br><i>N/A</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>                   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><i>3909 Duvall Avenue</i>   |  |   |  | 10f. Zip Code  |  | 10g. Citizen of What Country?<br><i>USA</i>                       |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>12</i>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Lab Technician Instructor US Government</i>   |  |   | 16b. Kind of Business/Industry<br><i>US Government</i>                  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Lawrence R. Nelson</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Elizabeth Rush</i>   |  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print) <i>(Niece)</i><br><i>Ms. Little Myers</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2316 Ivy Ave. Balt., MD 21214</i>  |  |   |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>Bayview Cemetery</i>  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Bayview Cemetery</i>  |  | Date <i>5/14/12</i>   | 20c. Location - City or Town, State<br><i>Dundalk, MD</i>               |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Patricia G. Harris, L.M.H. 2228 W. North Ave. Balt., MD 21216</i>   |  |   |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home, P.A.</i>   |  |   |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>PNEUMONIA</i>  |  |   |  |  |  |   | Approximate Interval Between Onset and Death<br><i>MONTHS</i>           |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>URINARY TRACT INFECTION</i>  |  |   |  |  |  |   |   |  |
|  | 23b. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><i>Unknown</i>   |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DIABETES</i><br><i>DEGENERATIVE JOINT DISEASE</i><br><i>DEMENIA</i>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                                 |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |   |  |
|  | 29b. Signature and title of certifier<br><i>BHANUDEEP BAJAJ MD</i>  |  |   |  | 29c. License number<br><i>D0070917</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>MAY 9, 2012</i>         |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>BHANUDEEP BAJAJ</i>  |  |   |  | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>  |  |   |   |  |
|  | 32. Registrar's Signature<br><i>S. Parker</i>   |  |   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend Item 1 per doc g927 5-11-12 vt  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15088

1- For  
State  
Registrar

|  |  |  |  |   |  |  |   |  |
|--|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last) <b>Diana J. Richards</b>  |  |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>9</b> Year <b>2012</b>   | 3. Time of Death<br><b>11:54 PM</b>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>116 WALL STREET</b>   |  | 4b. City, Town, or Location of Death<br><b>QUEENSTOWN</b>  |   | 4c. County of Death<br><b>QUEEN ANNE</b>   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>095-30-8721</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months<br><b>0</b>   | If Under 24 Hrs.<br>Days<br><b>0</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>JANUARY 15, 1939</b>          | 9. Birthplace (State or Foreign Country)<br><b>NY</b> |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent<br>10a. State <b>VA</b> 10b. County <b>FAIRFAX</b> 10c. City, Town or Location <b>CENTERVILLE</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>14509 CHELSEY PLACE</b>   |  | 10f. Zip Code<br><b>21021</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>19</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>WHITE</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>RECEPTIONIST</b>  |   | 16b. Kind of Business/Industry<br><b>OFFICE</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN RUDOLF SCHMIDBERG</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE HONNICK</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>FRIEND</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>EUGENIE FITZGERALD P.O. BOX 306 QUEENSTOWN, MD 21658</b>   |   |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► JEFFREY L. UKENS</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARDENT CREMATION</b>  |   | Date<br><b>MAY 11, 2012</b>  | 20c. Location - City or Town, State<br><b>HANOVER, MD</b>                  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>JOSEPH L. CANBY</b>  |  | 22. Name and Address of Facility<br><b>MARZULLO FUNERAL CHAPEL 6009 HARTFORD ROAD BALTIMORE MD 21214</b>   |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death   |  |   |  |
|  | <p>a. <b>BREAST CANCER</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |   |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown                      |   | 23d. Date of delivery<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b>   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>FRIEND'S HOME</b> |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |   |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.               |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |   |  |
|  | 29b. Signature and title of certifier<br><b>JEFFREY L. UKENS</b>   |  | 29c. License number<br><b>D63747</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/10/12</b>  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEFFREY L. UKENS 2540 CENTREVILLE ROAD, CENTREVILLE MD 21617</b>  |  |  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |   |  |
| State Registrar  | 32. Registrar's Signature<br><b>Jeffrey L. UKENS</b>   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 19b per fh 8927 5-17-12 vt

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

Certificate of Death

Reg. No.

2012 15089

|  |  |   |   |  |   |  |  |   |  |   |
|--|--|---|---|--|---|--|--|---|--|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> , Year <b>2012</b>  | 3. Time of Death<br><b>5:35A M</b>               |  |   |  |   |
|  | Richard Rothwell   |   |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>  |  | 4c. County of Death<br><b>Baltimore</b>                            |   |  |   |
| <b>Funeral<br/>Director</b>  | 4a. Facility Name (if not institution, give street and number)<br><b>717 Maiden Choice Lane Apt 625</b>  | 5. Social Security Number<br><b>579-52-8109</b>   | 6. Sex<br><b>1 XX 2 F</b>   | 7. Age (in yrs. last birthday)<br><b>99 Yrs.</b>                             | If Under 1 Year<br>Months <b>1</b>  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b> | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/23/1912</b>        | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>     |  |   |
| <b>To Be Completed by Funeral Director</b>   | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Baltimore</b>   |   |   |  | 10c. City, Town or Location<br><b>Catonsville</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  | 10e. Street and Number<br><b>717 Maiden Choice Lane, Apt. 625</b>  |   |   |  | 10f. Zip Code<br><b>21228</b>   |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>USMC</b><br>If Yes, Give Year or Dates.<br><b>1936-1961</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>4</b>                                   |  | 16b. Kind of Business Industry<br><b>U. S. Marine Corps Officer</b>   |  |  |   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Richard Raymond Rothwell</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Duffy</b>   |  |  |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rebecca Rothwell / Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City, State, Zip Code)<br><b>717 Maiden Choice Lane, Apt. 625 Catonsville, Md 21228</b>                                      |  |  |   |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Huntt Crematory</b>  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date<br><b>5/10/2012</b>   | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b>         |  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert E. Evans</b>  |   |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home<br/>16000 Annapolis Road, Bowie, Maryland 20715</b>   |  |  |   |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |   |  | Approximate Interval Between Onset and Death  |
|  | <p>a. Due to (or as a consequence of):<br/><i>Arteriosclerotic Cardiovascular Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |   |   |  |   |  |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |   |  | 23d. Date of delivery<br>Month <b>0</b> Day <b>0</b> Year <b>0</b> |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  |  |   |   |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                |  |   |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |   |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |  |   |  |   |
| 29b. Signature and title of certifier<br><b>Robert E. Evans</b>  |  | 29c. License number<br><b>0020090</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/12</b>  |  |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert E. Evans 717 Maiden Choice Lane Catonsville, MD 21228</b>  |  |   |   |  |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Robert E. Evans</b>   |   |  |   |  |  |   |  |   |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15090

1 - For  
State  
Registrar

|  |   |   |  |   |  |   |  |  |
|--|---|---|--|---|--|---|--|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>                         | 1. Decedent's Name (First, Middle, Last)<br><b>Anne Kraft Ratcliffe</b>   |   |  |   |  | 2. Date of Death<br>Month <b>5</b> Day <b>8</b> Year <b>2012</b>  | 3. Time of Death<br><b>9:20 A M</b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>8804 Earl Court</b>  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>395-01-9451</b>   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (in yrs. last birthday)<br><b>100</b> Yrs.  | If Under 1 Year<br>Months      Days      Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>2-28-1912</b> | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>   | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Bethesda</b>   |   |  |   |  |  |
|  | 10e. Street and Number<br><b>8804 Earl Court</b>  |   |  | 10f. Zip Code<br><b>20817</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 4</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Homemaker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Morris Kraft</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Chernin</b>  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Blitz - Daughter</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8804 Earl Court, Bethesda, Maryland 20817</b> |  |   |  |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                         | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Mem. Gardens</b>  | Date<br><b>5-10-2012</b>   | 20c. Location - City or Town, State<br><b>Olney, Maryland</b>   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Edward Sagel</b>  | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction<br/>M00910 1091 Rockville Pike, Rockville, Maryland 20852</b>   |  |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Atherosclerosis</b>   |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |
|  | a. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |  |   |  |  |
|  | b. Due to (or as a consequence of):   |   |  |   |  |   |  |  |
|  | c. Due to (or as a consequence of):   |   |  |   |  |   |  |  |
|  | d. _____  |   |  |   |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>   |  |   | 23d. Date of delivery<br>Month      Day      Year          |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b> |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
|  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |   |  |   |  |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   | 28d. Describe how injury occurred                          |   |  |  |
|  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>G. Cole</b>   | 29c. License number<br><b>D37142</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-8-2012</b>     |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Geoffrey Coleman, MD- 1355 Piccard Drive, Ste#100, Rockville, Maryland 20850</b>   |   |  |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   | 32. Registrar's Signature<br><b>Leanne J. Parker</b>  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

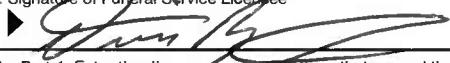
Reg. No. 2012 15091

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

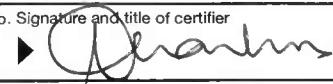
|   |   |   |   |                                |   |   |  |
|---|---|---|---|--------------------------------|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DONALD W. REDIFER</b>  |   |   | 2. Date of Death<br>Month Day Year<br><b>MAY 7, 2012</b>  |                                |   |   | 3. Time of Death<br>3:42A M  |
| 4a. Facility Name (if not institution, give street and number)<br><b>GILCHRIST HOSPICE</b>  |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |                                |   | 4c. County of Death<br><b>BALTO.</b>                                    |  |
| 5. Social Security Number<br><b>217-40-6436</b><br>Usual Residence of Decedent  |   | 6. Sex<br><b>1 X M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>69</b><br>Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth<br>(Month, Day, Year)<br><b>10-2-1942</b>              | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |
| 10a. State<br><b>MD.</b>  | 10b. County<br><b>HARFORD</b>   | 10c. City, Town or Location<br><b>BEL AIR</b>   |   |                                |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>1065 WINGATE COURT</b>   |   |   | 10f. Zip Code<br><b>21014</b>   |                                |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESMAN</b> |   |                                | 16b. Kind of Business/Industry<br><b>TIRE COMPANY</b> |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>WALLACE L. REDIFER</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIE J. LIBERTO</b>  |                                |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>COLLEEN CARROLL</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1065 WINGATE COURT BEL AIR, MD. 21014</b>   |                                |   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ATLANTIC CREMATORY</b>   |                                |   | Date<br><b>5-9-2012</b>   | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                                     |
| 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME OF BEL AIR<br/>610 W. MACPHAIL ROAD BEL AIR, MD. 21014</b>  |                                |   |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |                                     |  |  |  |
|--|--|---|-------------------------------------|--|--|--|
| 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | <b>Dementia, Frontotemporal</b>   |                                     |  | Approximate Interval Between Onset and Death<br><b>4 years</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):   | b. Due to (or as a consequence of): | c. Due to (or as a consequence of):  | d. _____   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown             |                                     |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                     |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |                                     |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  |  |   |                                     |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |                                     |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                     |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>DS8303</b>  |                                     |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 7 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Aaron S Charles MD 6701 N Charles St Towson MD</b>  |  |   |                                     |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |                                     |  |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

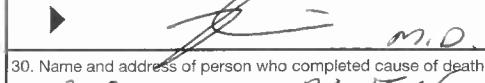
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15092

**1 - For  
State  
Registrar**

**Physician/  
Medical  
Examiner**

|   |  |  |                    |   |   |   |  |  |   |
|---|--|--|--------------------|---|---|---|--|--|---|
|   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles A. Ridgway</b>  |                    |   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> Year <b>2012</b>   | 3. Time of Death<br><b>02:45 AM</b>   |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>Loch Raven CLC</b>  |                    |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   | 4c. County of Death   |
| <b>Funeral<br/>Director</b>   |  | 5. Social Security Number<br><b>216-32-4512</b>  | 6. Sex<br><b>M</b> | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 30, 1935</b>                       | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |
|   |  | Usual Residence of Decedent<br><b>Baltimore</b>  |                    | 10a. State <b>MD</b> 10b. County <b>Baltimore</b> |   |   |  | 10c. City, Town or Location <b>Lansdowne</b>   |   |
| <b>To Be Completed by Funeral Director</b>                                |  | 10e. Street and Number<br><b>121 Third Avenue</b>  |                    |   |   | 10f. Zip Code<br><b>21227</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                    |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b>   |                    |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Machineist</b>   |   |  | 16b. Kind of Business/Industry<br><b>Brewery</b>   |   |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>John R. Ridgway</b>  |                    |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary M. Brown</b>   |   |  |  |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles W. Ridgway / Son</b>  |                    |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Wake Forest Court Catonsville, MD 21228</b>  |   |  |  |   |
|   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park</b>  |   | Date<br><b>May 8, 2012</b>   | 20c. Location - City or Town, State<br><b>Elkridge, MD</b>   |   |
|   |  | 21. Signature of Funeral Service Licensee<br>   |                    |   | 22. Name and Address of Facility<br><b>Ambrose Funeral Home of Lansdowne<br/>2719 Hammonds Ferry Road Lansdowne, MD 21227</b>   |   |  |  |   |
|   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |                    |   | <i>Carcinoma of Esophagus</i>   |   |  | Approximate Interval Between Onset and Death   |   |
|   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |                    |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year  |   |
|   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                    |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
|   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                    |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |                    |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                    |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                    |   |   |   |  |  |   |
|   |  | 29b. Signature and title of certifier<br>   |                    |   | 29c. License number<br><b>P56508</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>   |   |
|   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>3800 LOCH RAVEN BLVD.</b>   |                    |   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   |  | 32. Registrar's Signature<br>   |   |

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15093

1 - For State Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |                                |                 |  |                             |                                     |  |   |
|---|--|---|--------------------------------|-----------------|--|-----------------------------|-------------------------------------|--|---|
| Physician/<br>Medical<br>Examiner   |  | Certificate of Death  |                                |                 |  |                             |                                     |  |   |
|   |  | Decedent's Name (First, Middle, Last)   |                                |                 | Date of Death  |                             | Reg. No.                            |  |   |
| 1. Decedent's Name (First, Middle, Last)  |  | Jesus, Ramos  |                                |                 | Month  | Day                         | Year                                |  |   |
| 4a. Facility Name (if not institution, give street and number)  |  | St. Elizabeth Rehab Center  |                                |                 | 4b. City, Town, or Location of Death   |                             | 4c. County of Death                 |  |   |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year |  | If Under 24 Hrs.            |                                     | 8. Date of Birth<br>(Month, Day, Year)   | 9. Birthplace (State or Foreign Country)                            |
| 212-92-8124   |  | <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 91 Yrs.                        | Months          | Days   | Hours                       | Min.                                | Jan. 29, 1921  | Philippines   |
| Usual Residence of Decedent   |  | 10a. State  |                                | 10b. County     |  | 10c. City, Town or Location |                                     |  | 10d. Inside City Limits   |
|   |  | MD  |                                | Baltimore       |  | Catonsville                 |                                     |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number  |  | 6700 Hamerson Road  |                                |                 | 10f. Zip Code  |                             |                                     | 10g. Citizen of What Country?  |   |
|   |  |   |                                |                 | 21228  |                             |                                     | USA  |   |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                |                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)                           |                             |                                     | 14. Race - American Indian, Black, White, etc.   |   |
| <input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                |                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:  |                             |                                     | <input type="checkbox"/> Filipino  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)  |  | Elementary/Secondary (0-12)   |                                |                 | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)                           |                             |                                     | 16b. Kind of Business Industry   |   |
|   |  | College (1-4 or 5+)<br>5+   |                                |                 | Principal  |                             |                                     | Education  |   |
| 17. Father's Name (First, Middle, Last)   |  | Nicomedes Generoso  |                                |                 | 18. Mother's Name (First, Middle, Maiden Surname)  |                             |                                     | Teodorica Madrileno  |   |
| 19a. Informant's Name/Relationship (Type, Print)  |  | Maria Maximo Sabundayo-Daughter   |                                |                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                             |                                     |  |   |
|   |  |   |                                |                 | 6700 Hamerson Road; Catonsville, MD 21228  |                             |                                     |  |   |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                |                 | Date   |                             | 20c. Location - City or Town, State |  |   |
| <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | Woodlawn Cemetery   |                                |                 | 5/18/2012  |                             | Woodlawn, MD                        |  |   |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |                 | Sterling Ashton Schwab Witzke  |                             |                                     |  |   |
|   |  | Funeral Home of Catonsville, Inc.<br>1630 Edmondson Avenue; Catonsville, MD 21228   |                                |                 |  |                             |                                     |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  | 23b. Approximate Interval Between Onset and Death   |                                |                 |  |                             |                                     |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |  | Coronary artery disease   |                                |                 |  |                             |                                     |  |   |
| c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Atrial fibrillation   |                                |                 |  |                             |                                     |  |   |
| d.  |  | Anemia  |                                |                 |  |                             |                                     |  |   |
| IF FEMALE:  |  | Due to (or as a consequence of):  |                                |                 |  |                             |                                     |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | Coronary artery disease   |                                |                 |  |                             |                                     |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |  | Atrial fibrillation   |                                |                 |  |                             |                                     |  |   |
| 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (Specify)  |  | Anemia  |                                |                 |  |                             |                                     |  |   |
| 23d. Date of delivery<br>Month Day Year   |  | Diabetes  |                                |                 |  |                             |                                     |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | Chronic kidney disease  |                                |                 | 23e. Did tobacco use contribute to the cause of death?   |                             |                                     |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Cardiomyopathy  |                                |                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                             |                                     |  |   |
| Hospital:   |  | Recent gastrointestinal bleed   |                                |                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                  |                             |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 26. Place of Death (Check only one)   |  | 27. Manner of Death   |                                |                 | 28a. Date of injury<br>(Month, Day, Year)  |                             |                                     | 28b. Time of injury  |   |
| Other:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | <input checked="" type="checkbox"/> Natural<br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide |                                |                 | M  |                             |                                     | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 28d. Describe how injury occurred   |  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined  |                                |                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                             |                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |                                |                 | 29c. License number  |                             |                                     | 29d. Date signed (Month, Day, Year)  |   |
|   |  |   |                                |                 | 055-391  |                             |                                     | May 09, 2012   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  | Ming Y, MD 3320 Benson Avenue, Baltimore, Maryland 21227  |                                |                 |  |                             |                                     |  |   |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature   |                                |                 |  |                             |                                     |  |   |
| MAY 11 2012   |  |   |                                |                 |  |                             |                                     |  |   |

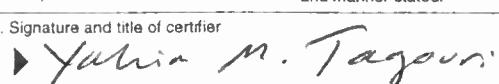
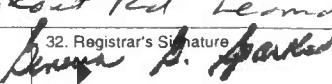
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For  
State  
Registrar

Amend Item 26 per verb., g927, 05/11/2012 dhp  
Certificate of Death

Reg. No.

2012 15094

|                                     |  |  |   |   |  |  |  |   |   |   |  |
|-------------------------------------|--|--|---|---|--|--|--|---|---|---|--|
| Physician /Medical Examiner         | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN ALAN SHERBERT</b>  |  |   |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 2012</b> | 3. Time of Death<br><b>11:44 PM</b>                     |   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Civista Medical Center</b>  |  |   | 4b. City, Town, or Location of Death<br><b>La Plata</b> |  |  | 4c. County of Death<br><b>Charles</b>  |   |   |   |  |
| Funeral Director                    | 5. Social Security Number<br><b>220-74-2429</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>52</b><br>Yrs.   | If Under 1 Year<br>Months                               | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT. 27, 1959</b>   | 9. Birthplace (State or Foreign Country)<br><b>OHIO</b>  |   |   |   |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>CHARLES</b> 10c. City, Town or Location<br><b>LA PLATA</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |   |   |   |  |
|                                     | 10e. Street and Number<br><b>9848 CHARLES STREET</b>   |  |   | 10f. Zip Code<br><b>20646</b>                           |  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |   |   |   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br>Specify: <b>WHITE</b> |  |  | 14. Race - American Indian, Black, White, etc.        |   |   |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>OFFICE ADMINISTRATOR</b>   |   | 16b. Kind of Business/Industry<br><b>LAW FIRM</b>  |  |  |   |   |   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>DONALD M. SHERBERT</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DELORES JEAN WOOD</b>  |  |  |   |   |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>JOAN K. SHERBERT/SPOUSE</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9848 CHARLES STREET LA PLATA, MD 20646</b>   |  |  |   |   |   |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DENTSVILLE METH.CEM. 2012</b>  |   | 20c. Location - City or Town, State<br><b>LA PLATA, MD</b>   |  |  |   |   |   |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNL. SERVICE, P.A.</b><br><b>5635 WASHINGTON AVE., LA PLATA, MD 20646</b>   |   |  |  |  |   |   |   |  |
| Physician /Medical Examiner         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |   | Approximate Interval Between Onset and Death            |   |  |
|                                     | <p>a. <i>Ischemic heart disease</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Hypertension</i><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>  |  |   |   |  |  |  |   |   |   |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |   |   |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |   |   |  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |   | Cther: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day Year)  |   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                             | 28d. Describe how injury occurred  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.       |  | 29c. License number<br><b>D0050883</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/2/12</b>   |  |   |   |   |  |
|                                     | 29b. Signature and title of certifier<br>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>25500 80 st at Lookout Rd Leonardtown MD 20650</b>   |   |  | 32. Registrar's Signature<br> |  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b> |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 29c, per DVR, g927 5-11-12 sm

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2012 15095

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

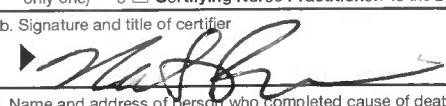
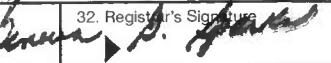
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

|   |  |                                |   |                                |   |   |  |
|---|--|--------------------------------|---|--------------------------------|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  |                                | 2. Date of Death<br>Month Day Year  |                                |   | 3. Time of Death  |  |
| Hank W Smith  |  |                                | 5 16 2012   |                                |   | 2053 M  |  |
| 4a. Facility Name (if not institution, give street and number)  |  |                                | 4b. City, Town, or Location of Death  |                                |   | 4c. County of Death   |  |
| Shock Trauma  |  |                                | Baltimore   |                                |   |   |  |
| 5. Social Security Number   | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days       | 8. Date of Birth<br>(Month, Day, Year)  | 9. Birthplace (State or Foreign Country)  |  |
| 215-58-2339<br>Usual Residence of Decedent  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 59 Yrs.                        |   |                                | 10/15/1952  | Maryland  |  |
| 10a. State  | 10b. County  | 10c. City, Town or Location    |   |                                |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| MD  | Harford  | Havre de Grace                 |   |                                |   |   |  |
| 10e. Street and Number  |  |                                | 10f. Zip Code   |                                |   | 10g. Citizen of What Country?   |  |
| 2304 Manor Circle   |  |                                | 21078   |                                |   | U.S.A.  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11  |  |                                | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Back Hoe Operator   |                                |   | 16b. Kind of Business/Industry<br>Construction  |  |
| 17. Father's Name (First, Middle, Last)<br>John Henry Smith   |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ann Lee Dare   |                                |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Rita Brown / Sister   |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2304 Manor Circle, Havre de Grace, MD 21078  |                                |   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Anatomy Gifts Registry  |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Anatomy Gifts Registry  |                                |   | Date 05/09/2012   | 20c. Location - City or Town, State<br>Hanover, Maryland   |
| 21. Signature of Funeral Service Licensee<br>  |  |                                | 22. Name and Address of Facility<br>Anatomy Gifts Registry<br>7522 Connelley Dr., Ste. P, Hanover, MD 21076   |                                |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |                                |   |                                |   |   |  |
| <p>a. <u>Traumatic Brain Injury</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Pedestrian struck by vehicle</u><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |                                |   |                                |   |   |  |
| Approximate Interval Between Onset and Death<br>   |  |                                |   |                                |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |                                | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                                |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                |   |                                |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                |   |                                |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |                                |   | 23f. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |                                | 28a. Date of injury<br>(Month, Day, Year)<br>4-27-12  | 28b. Time of injury<br>UNKNOWN | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><u>Pedestrian struck by auto</u>   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway   |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>UNKNOWN   |                                |   |   |  |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                |   |                                |   |   |  |
| 29b. Signature and title of certifier<br>  |  |                                | 29c. License number<br>P27377   |                                |   | 29d. Date signed (Month, Day, Year)<br>5-10-12  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Nathaniel Poston 22 South Greene St Baltimore MD 21201  |  |                                |   |                                |   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012  |  |                                | 32. Registrar's Signature<br>  |                                |   |   |  |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15096

1- For State Registrar

|  |   |  |  |   |  |   |  |   |  |   |                                      |   |
|--|---|--|--|---|--|---|--|---|--|---|--------------------------------------|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT Sholtes</b>   |  |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 6 2012</b>                 | 3. Time of Death<br>A.M./P.M.<br><b>11:45 A.M.</b>               |   |                                      |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Kris Leigh Assisted Living Facility</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Davidsonville</b>   |   |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |   |                                      |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>184-16-3221</b>   |  | 6. Sex<br><b>X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>90</b><br>Yrs. | If Under 1 Year<br>Months<br><b>0</b>  | If Under 24 Hrs.<br>Days<br><b>0</b>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 28, 1921</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>         |  |   |                                      |   |
|  | Usual Residence of Decedent   |  |  |   | Hours<br><b>0</b>  | Min.<br><b>0</b>  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                   |   |  |   |                                      |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>   |  |  |   | 10b. County<br><b>Allegheny</b>  | 10c. City, Town or Location<br><b>Swissvale</b>   |  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                     |   |                                      |   |
|  | 10e. Street and Number<br><b>2241 South Braddock Avenue</b>   |  |  |   | 10f. Zip Code<br><b>15218</b>  |   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |   |                                      |   |
|  | 11. Marital Status<br><b>1 Never Married 2 Married<br/>3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 No<br/>If Yes, Give Year or Dates.<br/>Unknown</b> |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 X No</b><br>Specify:<br><b>White</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |  |   |                                      |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Pipe Fitter</b>               |   |  | 16b. Kind of Business/Industry<br><b>Westinghouse</b>                   |  |   |                                      |   |
| Baltimore, Maryland 21215-0036   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Sholtes</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Belle Sombo</b>   |   |  |   |  |   |                                      |   |
| Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 19a. Informant's Name/Relationship (Type, Print)<br><b>Trina Dee/Daughter</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>638 Teton Court, Lothian, Maryland 20711</b> |   |  |   |  |   |                                      |   |
| Physician/<br>Medical<br>Examiner  | 20a. Method of Disposition<br><b>1 X Burial 2 Cremation 3 Removal from State<br/>4 Donation 5 Other (Specify)</b>   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Braddock Catholic Cem.</b>  |   |  | Date<br><b>5/11/2012</b>  | 20c. Location - City or Town, State<br><b>Braddock Hills, PA</b> |   |                                      |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner   | 21. Signature of Funeral Service Licensee<br><b>Dr. Charles</b>   |  |  |   | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home,<br/>16000 Annapolis Road, Bowie, Maryland 20715</b>                         |   |  |   |  |   |                                      |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Gastric intestinal cancer</b>  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |                                      |   |
|  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No<br/>9 Unknown</b>  |  |  |   |  |   |  |   |  |   |                                      |   |
|  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy<br/>4 Pregnant at time of death 5 Other (specify)<br/>9 Unknown</b>  |  |  |   |  |   |  |   |  | 23d. Date of delivery<br>Month Day Year   |                                      |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |                                      |   |
|  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |                                      |   |
|  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |  |   |  |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b><br><b>Associated Cancers</b> |                                      |   |
|  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide<br/>5 Pending Investigation 6 Could not be determined</b>   |  |  |   |  |   |  |   |  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury<br/>M</b><br>28c. Injury at work?<br><b>1 Yes 2 No</b>   | 28d. Describe how injury occurred    |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                      |   |
|  | 29a. Certifier<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |   |  |   |  |   |  | 29b. Signature and title of certifier<br><b>Dr. Charles</b>   | 29c. License number<br><b>015872</b> | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b> |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Karen Bob 6934 Avanlon Blvd Glen Burnie 21061</b>  |  |  |   |  |   |  |   |  |   |                                      |   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  |  |   | 32. Registrar's Signature<br><b>Karen J. Parker</b>  |   |  |   |  |   |                                      |   |

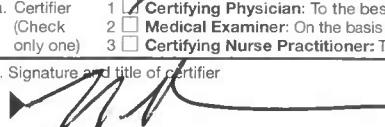
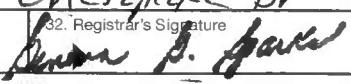
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15097

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |   |   |   |   |  |   |  |   |  |  |
|-------------------------------------|--|---|---|---|---|--|---|--|---|--|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>Frederick O. Smith</b>   |   |   |   |  | 2. Date of Death<br>05 Month 04 Day 2012 Year                           |  | 3. Time of Death<br>4:31 P M                                |  |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>702 Sharps Court</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Fallston</b>   |  |   | 4c. County of Death<br><b>Harford</b>  |   |  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>192-24-3023</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | Hours   | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/24/1929</b> | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Fallston</b>  |   |  |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                     |  | 10e. Street and Number<br><b>702 Sharps Court</b>   | 10f. Zip Code<br><b>21047</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |  |
|                                     |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>   | Elementary/Secondary (0-12)   | College (1-4 or 5+)   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Quality Control Inspector</b>                      |  |   | 16b. Kind of Business/Industry<br><b>Can Company</b>   |   |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Ralph Smith</b>   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Firve</b>   |   |   |  |   |  |   |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elaine I. Smith</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>702 Sharps Ct., Fallston, MD 21047</b>  |   |   | Date   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |   |  |  |
|                                     |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>   |   |   | 05/08/2012   |   |  |   |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br>  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 21014</b>   |   |   |  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |   |  |   | Approximate Interval Between Onset and Death   |  |
|                                     |  | <p>a. Due to (or as a consequence of):<br/><b>Congestive Heart Failure</b></p> <p>b. Due to (or as a consequence of):<br/><b>Coronary Artery Disease</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |   |  |   |  |   |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
|                                     |  |   |   |   |   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA   |   | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |
|                                     |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury   | M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |   |  |  |
|                                     |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |   |  |  |
|                                     |  | 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |   |  |  |
|                                     |  | 29b. Signature and title of certifier<br>  | 29c. License number<br><b>D 68235</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b>                            |   |  |   |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>520 Upper Chesapeake Dr #308 Bel Air, MD 21014</b>   |   |   |   |  |   |  |   |  |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   | 32. Registrar's Signature<br>  |   |   |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

Important: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15098

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Wilmer Sadler</b>  |  | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>7:40 P M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Bel Air Health and Rehabilitation Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  | 4c. County of Death<br><b>Harford</b>  |
| 5. Social Security Number<br><b>213-20-1146</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs.  | If Under 1 Year<br>Months      Days      Hours      Min.                         |
|  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Bel Air</b>  |  |
| 10e. Street and Number<br><b>2015 Cypress Drive</b>  |  | 10f. Zip Code<br><b>21015</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br><b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>   | 16b. Kind of Business Industry<br><b>Vending</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elmer Francis Sadler</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Mary Horak</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Theodore Sadler / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>101 Mt. Rocky Lane, Colora, Maryland 21917</b>   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Rose Hill Svcs. LLC</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date<br><b>5-10-2012</b>   | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>                  |
| 21. Signature of Funeral Service Licensee<br><b>Stefan A. Reynolds</b>   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death   |  |  |
| a. Due to (or as a consequence of):<br><b>Coronary artery disease</b>  |  |  |  |  |
| b. Due to (or as a consequence of):  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |  |
| d. _____   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month      Day      Year                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>COPD</b><br><b>failure to thrive</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D 0063981</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>05/08/2012</b>                         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Benjamin Lee, MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  |  |
|  |  | 32. Registrar's Signature<br><b>Laura J. Parks</b>   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15099

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

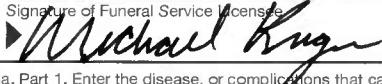
Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Schwartz, Allen

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 5 Day 8 Year 2012  |   |   |  | 3. Time of Death<br>20A M   |  |  |  |
| ALLEN SCHWARTZ   |  | Baltimore City   |   |   |  | N/A   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>Sinai Hospital of Baltimore  |  | 4b. City, Town, or Location of Death<br>Baltimore City   |   |   |  | 4c. County of Death<br>N/A  |  |  |  |
| 5. Social Security Number<br>214-76-2986<br>Usual Residence of Decedent<br>N/A   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br>10/26/1937  | 9. Birthplace (State or Foreign Country)<br>NY   |  |  |
| 10a. State<br>MD   |  | 10b. County<br>N/A   |   | 10c. City, Town or Location<br>BALTIMORE  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br>5901 1/2 BLAND AVENUE  |  | 10f. Zip Code<br>21215   |   |   | 10g. Citizen of What Country?<br>USA   |   |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>NONE   |   | 16b. Kind of Business/Industry<br>NONE  |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>MORRIS  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>SCHWARTZ RAE KOHEN  |   |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>PAMELA KLECAN/PERSONAL REP   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>201 E. BALTIMORE ST, 15TH FLR, BALTIMORE, MD 21202  |   |   |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>BETH JACOB CONGR.  |   | Date<br>05/10/2012  | 20c. Location - City or Town, State<br>FINKSBURG, MD   |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKEVILLE, MD 21208  |   |   |  |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Respiratory Arrest   |   |   | Approximate Interval Between Onset and Death<br>10 min.  |   |  |  |  |
| a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |  |  |   |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |   |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Mental Retardation<br>Hypertension   |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br>MAY 11 2012  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>AJAY S. MOODA, 2401 W. Belvedere Ave, Baltimore MD 21215 |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D 68705   |   |   | 29d. Date signed (Month, Day, Year)<br>5/8/2012  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>AJAY S. MOODA, 2401 W. Belvedere Ave, Baltimore MD 21215   |  |  |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>   |   |   |  |   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15100

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

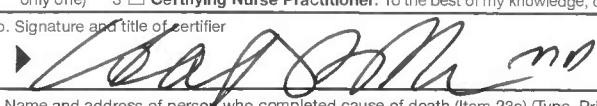
Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
|--|--|--|--|--|---|---|--|----|--|----|----------------------------------|----|----------------------------------|----|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |  |  |   | 3. Time of Death<br>150 P M                                 |  |    |  |    |                                  |    |                                  |    |  |
| <i>WILLIAM SNYDER</i>  |  | <i>May 3 2012</i>  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Seasons Hospice</b>   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>  |  |  |   | 4c. County of Death<br><b>Baltimore</b>                     |  |    |  |    |                                  |    |                                  |    |  |
| 5. Social Security Number<br><b>219 03 4777</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>01 12 1921</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |    |  |    |                                  |    |                                  |    |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Millersville</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |    |  |    |                                  |    |                                  |    |  |
| 10e. Street and Number<br><b>8304 Brightview Court</b>   |  |  | 10f. Zip Code<br><b>21108</b>                    |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |  |    |  |    |                                  |    |                                  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1944-1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:        |   |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                 |    |  |    |                                  |    |                                  |    |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 5</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Firefighter</b>   |  | 16b. Kind of Business/Industry<br><b>Baltimore City Fire Department</b>  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Charles Snyder</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Katherine Reeb</b>   |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Snyder - Son</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8304 Brightview Ct. Millersville, MD 21108</b> |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>MD Veterans Cem</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cem</b>   |  | Date<br><b>05 08 12</b>  | 20c. Location - City or Town, State<br><b>Crownsville, MD</b>                               |   |  |    |  |    |                                  |    |                                  |    |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>GJ Gonce Funeral Home, PA<br/>169 Riviera Drive Pasadena, MD 21122</b>  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebral Thrombosis</b>   |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| Approximate Interval Between Onset and Death   |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| <table border="1"> <tr> <td>a.</td> <td>Due to (or as a consequence of):<br/><br/><i>Cerebral Thrombosis</i></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>  |  |  |  |  |   |   |  | a. | Due to (or as a consequence of):<br><br><i>Cerebral Thrombosis</i> | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. |  |
| a.   | Due to (or as a consequence of):<br><br><i>Cerebral Thrombosis</i> |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| b.   | Due to (or as a consequence of):                                   |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| c.   | Due to (or as a consequence of):                                   |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| d.   |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown          |  |  |   | 23d. Date of delivery<br>Month Day Year                     |  |    |  |    |                                  |    |                                  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Hospital <i>Hospital</i> |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred                           |  |    |  |    |                                  |    |                                  |    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D15872</b>   |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 4, 2012</b>  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barbara Bob 6934 Aviation Blvd Glen Burnie 21061</b>  |  |  |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>   |  |  |   |   |  |    |  |    |                                  |    |                                  |    |  |

ORIGINAL

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15101

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |                                |  |                                     |
|--|--|---|--------------------------------|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death  |                                | 3. Time of Death   |                                     |
| <i>Sarah E. Travers</i>  |  | Month <i>May</i> Day <i>5</i> Year <i>2012</i>  |                                | 5:20 AM  |                                     |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |                                | 4c. County of Death  |                                     |
| <i>Seasons Hospice Center</i>  |  | <i>Randallstown</i>   |                                | <i>Baltimore</i>   |                                     |
| 5. Social Security Number  |  | 6. Sex  | 7. Age (in yrs. last birthday) | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours           |
| <i>212-60-3866</i>   |  | <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | <i>57</i> Yrs.                 |  | Min.                                |
| 8. Date of Birth<br>(Month, Day, Year)   |  | 9. Birthplace (State or Foreign Country)  |                                | 10d. Inside City Limits  |                                     |
| <i>5/22/1954</i>   |  | <i>Maryland</i>   |                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                     |
| 10a. State   |  | 10b. County   |                                | 10c. City, Town or Location  |                                     |
| <i>MD</i>  |  | <i>N/A</i>  |                                | <i>Baltimore</i>   |                                     |
| 10e. Street and Number   |  | 10f. Zip Code   |                                | 10g. Citizen of What Country?  |                                     |
| <i>2014 Presbury Street</i>  |  | <i>21217</i>  |                                | <i>USA</i>   |                                     |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |                                     |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |                                     |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |                                | 16b. Kind of Business/Industry   |                                     |
| Elementary/Secondary (0-12) <i>11</i>  |  | College (1-4 or 5+) <i>0</i>  |                                | <i>Laborer</i> <i>Warehouse</i>  |                                     |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |  |                                     |
| <i>James Minngie</i>   |  | <i>Dorothy Travers</i>  |                                |  |                                     |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |                                     |
| <i>Ms. Lillian Travers (Sister)</i>  |  | <i>5624 Woodmount Ave. Balt., MD 21239</i>  |                                |  |                                     |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date   | 20c. Location - City or Town, State |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Odyssey Gray</i>  |  | <i>Trinity Cemetery</i>   |                                | <i>5/12/12</i>   | <i>Hendalk, MD</i>                  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility  |                                |  |                                     |
| <i>Odyssey Gray</i>  |  | <i>Joseph Russ Funeral Home, P.A.</i>   |                                |  |                                     |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><i>Lung Cancer</i>   |                                | Approximate Interval Between Onset and Death<br><i>1 month</i>   |                                     |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):  |                                |  |                                     |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown                       |                                | 23d. Date of delivery<br>Month Day Year  |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                     |
|  |  |   |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                     |
|  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                     |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Inpatient Hospice</i> |                                |  |                                     |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M       | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                     |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |                                     |
| 29b. Signature and title of certifier<br><i>Karen W. Merritt MD</i>  |  | 29c. License number<br><i>DO043375</i>  |                                | 29d. Date signed (Month, Day, Year)<br><i>05/05/2012</i>   |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |                                |  |                                     |
| <i>Karen W. Merritt MD 6934 AVIATION BLVD SUITE N-2 GREENBELT MD 21061</i>   |  |   |                                |  |                                     |
| 31. Date filed (Month, Day, Year)  |  | 32. Registrar's Signature   |                                |  |                                     |
| <i>MAY 11 2012</i>   |  | <i>Leanne J. Parker</i>   |                                |  |                                     |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15102

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Jace Bryan Thomas

2. Date of Death

Month

Day

Year

3. Time of Death

0838 AM

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

University of Maryland Medical Ctr

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

infant

6. Sex

 M F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month Day, Year)

Apr 28, 2012

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Usual Residence of Decedent

MD

10c. City, Town or Location

Baltimore

10d. Inside City Limits

 Yes 2  No

10e. Street and Number

282 S. Mason Court

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

 Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
infantCollege (1-4 or 5+)  
infant16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

infant

16b. Kind of Business Industry

infant

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Tameeka Gilmore

19a. Informant's Name/Relationship (Type, Print)

University of MD Med Ctr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Physician/Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. *extreme prostrancy*  
Due to (or as a consequence of):b. *rupture of membranes prior to onset of labour.*c. *chorioamnionitis*  
Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15103

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

ROSARIO RAYOS del Sol TAYAG

2. Date of Death

Month  
05

Day  
08

Year  
2012

3. Time of Death

9:45 AM

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)  
FRANKlin Square Hospital

4b. City, Town, or Location of Death

RoseDAle

4c. County of Death

Baltimore

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5. Social Security Number  
381-72-1542

Usual Residence of Decedent

6. Sex  
1  M 2  F

7. Age (In yrs. last birthday)  
65 Yrs.

If Under 1 Year  
Months  
If Under 24 Hrs.  
Days Hours Min.

8. Date of Birth  
(Month, Day, Year)  
8-26-1946

3. Time of Death  
9:45 AM

9. Birthplace (State or Foreign Country)  
PHILIPPINES

10a. State  
MD.

10b. County  
BALTO.

10c. City, Town or Location

NOTTINGHAM

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

8 HEAVRIN COURT

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: ASIAN

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

BRAULIO RAYOS del Sol

18. Mother's Name (First, Middle, Maiden Surname)

PILAR FRANCISCO

19a. Informant's Name/Relationship (Type, Print)

JESUS G. TAYAG

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 HEAVRIN COURT NOTTINGHAM, MD. 21236

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY

Date

5-12-2012

20c. Location - City or Town, State

TIMONIUM, MD. 21093

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SCHIMUNEK FUNERAL HOME INC.

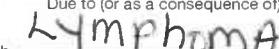
9705 BELAIR ROAD NOTTINGHAM, MD. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a.   
Due to (or as a consequence of):

b.   
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify) \_\_\_\_\_

9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural

2  Accident

3  Suicide

4  Homicide

5  Pending Investigation

6  Could not be determined

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D0062099

29d. Date signed (Month, Day, Year)

5/8/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Rayos MD 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15104

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |  |   |
|---|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><i>Margaret TANAVAGE</i>  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>8</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>6:20 P M</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><i>Season's Hospice</i>   |  | 4b. City, Town, or Location of Death<br><i>Randallstown</i>   |  | 4c. County of Death<br><i>Baltimore</i>   |
| 5. Social Security Number<br><b>195-20-1641</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>85 Yrs.</b> | If Under 1 Year<br>Months      Days      Hours      Min.  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>8-19-1926</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  | 10. Usual Residence of Decedent<br><b>Baltimore</b>   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |
| 10e. Street and Number<br><b>3730 Coronado Road</b>   |  | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>      |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>  |  | 16b. Kind of Business/Industry<br><b>Registered Nurse</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Patrick Conway</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Caffrey</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Bruchey Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3730 Coronado Road Baltimore MD 21244</b>   |  |   |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview</b>   |  | Date<br><b>5-11-2012</b>  |
| 20c. Location - City or Town, State<br><b>Sykesville MD</b>   |  |   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Brune</b>   |  | 22. Name and Address of Facility<br><b>Vaughn C. Brune Funeral Services<br/>8738 Liberty Road, Randallstown MD 21133</b>  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |  |   |
| a. <b>Atherosclerotic cardiovascular Disease</b><br>Due to (or as a consequence of):  |  |   |  |   |
| b. _____<br>Due to (or as a consequence of):  |  |   |  |   |
| c. _____<br>Due to (or as a consequence of):  |  |   |  |   |
| d. _____  |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>        |  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |
|   |  |   |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |
|   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Inpatient hospice</b> |  |   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br/>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br/>6 <input type="checkbox"/> Could not be determined</b>  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |
|   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |  |   |
| 29b. Signature and title of certifier<br><b>N S Rayapati MD</b>   |  | 29c. License number<br><b>DO057465</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/19/12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N S Rayapati MD 2835 Smith Av S 203 Baltimore MD 21209</b>   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne S. Sparks</b>  |  |   |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15105

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |             |   |  |   |  |
|--|-------------|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |             | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death  |  |
| <i>George Wilson</i>   |             | <i>May 8, 2012</i>  |  | <i>11:20 AM</i>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>7207 Friendship Road</i>  |             | 4b. City, Town, or Location of Death<br><i>Clinton</i>  |  | 4c. County of Death<br><i>Prince Georges</i>  |  |
| 5. Social Security Number<br><i>230-66-3090</i>  |             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>64</i> Yrs. | If Under 1 Year<br>Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>June 13, 1947</i>                                 |
| Usual Residence of Decedent  |             | 9. Birthplace (State or Foreign Country)<br><i>Virginia</i>   |  |   |  |
| 10a. State<br><i>Washington D.C.</i>   | 10b. County | 10c. City, Town or Location<br><i>Washington</i>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><i>3413 21st St. S.E.</i>  |             | 10f. Zip Code<br><i>20020</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i>Black</i> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>   |             | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Driver</i>   |  | 16b. Kind of Business/Industry<br><i>Red Top Cab Co.</i>  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Howard D. Wilson</i>   |             | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Dora Carr</i>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Brady Turner - Son</i>  |             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7207 Friendship Road Clinton, Maryland 20735</i>  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>Bethel Cemetery</i>  |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Bethel Cemetery</i>  |  | Date<br><i>5/16/2012</i>  | 20c. Location - City or Town, State<br><i>Alexandria, Virginia</i>                             |
| 21. Signature of Funeral Service Licensee<br><i>Robert B Baker Jr.</i>   |             | 22. Name and Address of Facility<br><i>Chinn Funeral Service<br/>2605 S. Shirlington Road Arlington, Virginia 22206</i>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>End stage Renal Cancer</i>  |             | Approximate Interval Between Onset and Death  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |             |   |  |   |  |
| a. Due to (or as a consequence of):<br><i>End stage Renal Cancer</i>   |             |   |  |   |  |
| b. Due to (or as a consequence of):  |             |   |  |   |  |
| c. Due to (or as a consequence of):  |             |   |  |   |  |
| d. Due to (or as a consequence of):  |             |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |             | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                     |  | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |             |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><i>Residence</i> |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |             | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>4041 Powdermill Road Suite 600 Calverton, Md. 20705</i>  |  |   |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             | 29c. License number<br><i>D63748</i>  |  |   |  |
| 29b. Signature and title of certifier<br><i>Jocelyne Kouatchou, MD</i>   |             | 29d. Date signed (Month, Day, Year)<br><i>5/8/2012</i>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Jocelyne Kouatchou 4041 Powdermill Road suite 600 Calverton, Md. 20705</i>  |             | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>   |  |   |  |
| 32. Registrar's Signature<br><i>J. Parker</i>  |             |   |  |   |  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15106

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                   |  |  |  |   |                          |  |                                     |  |  |
|-----------------------------------|--|--|--|---|--------------------------|--|-------------------------------------|--|--|
|                                   |  | 1. Decedent's Name (First, Middle, Last)   |  |   |                          | 2. Date of Death   |                                     | 3. Time of Death   |  |
|                                   |  | Marvin Weisblatt   |  |   |                          | Month 5 Day 5 Year 2012  |                                     | 16:40 M  |  |
|                                   |  | 4a. Facility Name (if not institution, give street and number)   |  |   |                          | 4b. City, Town, or Location of Death   |                                     | 4c. County of Death  |  |
|                                   |  | Shady Grove Hospital   |  |   |                          | Rockville  |                                     | Montgomery   |  |
| Funeral Director                  |  | 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. last birthday)  |                          | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days            | 8. Date of Birth<br>(Month, Day, Year)                           | 9. Birthplace (State or Foreign Country) |
|                                   |  | 577-54-5195  | <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 73  | Yrs.                     |  |                                     | 10-28-1938   | Washington, DC                           |
|                                   |  | Usual Residence of Decedent  |  |   |                          | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                     |  |  |
|                                   |  | 10a. State   | 10b. County  | 10c. City, Town or Location   |                          |  |                                     |  |  |
|                                   |  | MD   | Montgomery   | Montgomery Village  |                          |  |                                     |  |  |
|                                   |  | 10e. Street and Number   |  |   |                          | 10f. Zip Code  |                                     | 10g. Citizen of What Country?                                    |  |
|                                   |  | 8738 Ravenglass Way  |  |   |                          | 20886  |                                     | United States  |  |
|                                   |  | 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|                                   |  | 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |                          | 16b. Kind of Business Industry   |                                     |  |  |
|                                   |  | Elementary/Secondary (0-12)  |  | College (1-4 or 5+)   |                          | Accountant   |                                     | Federal Government   |  |
|                                   |  | 17. Father's Name (First, Middle, Last)  |  |   |                          | 18. Mother's Name (First, Middle, Maiden Surname)  |                                     |  |  |
|                                   |  | Leo Weisblatt  |  |   |                          | Rose Donzas  |                                     |  |  |
|                                   |  | 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                          | 20886  |                                     |  |  |
|                                   |  | Leslie Weisblatt - Wife  |  | 8738 Ravenglass Way, Montgomery Village, Maryland   |                          |  |                                     |  |  |
|                                   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                          | Date   | 20c. Location - City or Town, State |  |  |
|                                   |  |  |  | Beth El @ Forest Lawn   |                          | 5-8-12   | Richmond Virginia                   |  |  |
|                                   |  | 21. Signature of Funeral Service Licensee  |  | Brian Deibler   |                          | 22. Name and Address of Facility   | Danzansky-Goldberg                  |  |  |
|                                   |  |  |  | M01390  |                          | 1170 Rockville Pike, Rockville, Maryland 20852   |                                     |  |  |
| Physician/<br>Medical<br>Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |                          | Approximate Interval Between Onset and Death   |                                     |  |  |
|                                   |  | a. _____<br>Due to (or as a consequence of):   |  |   |                          |  |                                     |  |  |
|                                   |  | b. _____<br>Due to (or as a consequence of):   |  |   |                          |  |                                     |  |  |
|                                   |  | c. _____<br>Due to (or as a consequence of):   |  |   |                          |  |                                     |  |  |
|                                   |  | d. _____   |  |   |                          |  |                                     |  |  |
|                                   |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |                          | 23d. Date of delivery<br>Month Day Year  |                                     |  |  |
|                                   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>   |  |   |                          | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                     |  |  |
|                                   |  |  |  |   |                          | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                     |  |  |
|                                   |  |  |  |   |                          | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                     |  |  |
|                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |                          | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                              |                                     |  |  |
|                                   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred   |  |  |
|                                   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                     |  |  |
|                                   |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                          |  |                                     |  |  |
|                                   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D0064413   |                          | 29d. Date signed (Month, Day, Year)<br>May 5, 2010   |                                     |  |  |
|                                   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |                          |  |                                     |  |  |
|                                   |  | Juanita Smith, MD 9901 Medical Center Drive, Rockville, Maryland 20850   |  |   |                          |  |                                     |  |  |
| State Registrar                   |  | 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>   |                          |  |                                     |  |  |

Division of Vital Records, P.O. Box 68760

Case

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

WEISBLATT, MARVIN MAY 5, 2010 16:40  
 Baltimore, Maryland 21215-0036  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

A  
State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15107

**1- For State Registrar**

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| <b>Physician/<br/>Medical Examiner</b>     | 1. Decedent's Name (First, Middle, Last)<br><b>David Franklin Wilt Jr.</b>   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> Year <b>2012</b>     | 3. Time of Death<br><b>0244 hrs</b>  |  |
| <b>Funeral Director</b>                    | 4a. Facility Name (if not institution, give street and number)<br><b>East 695 prior to Route 2</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| <b>To Be Completed by Funeral Director</b> | 5. Social Security Number<br><b>216-94-0628</b>  | 6. Sex<br><b>1 [X] M 2 [ ] F</b>  | 7. Age (In yrs. last birthday)<br><b>33 Yrs.</b>  | If Under 1 Year<br>Months<br><b>03</b>   | If Under 24 Hrs.<br>Days<br><b>07</b>                                  | 8. Date of Birth (MM/DD/YYYY)<br><b>03/07/1979</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|  | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Pasadena</b>  |   |   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>503 Sunset Knoll Road</b>   |   |   | 10f. Zip Code<br><b>21122</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| <b>Physician/<br/>Medical Examiner</b>     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Painter</b>   | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>David F. Wilt Sr.</b>  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pamela Dalton</b>   |   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pamela Wilt (mother)</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2207 Hampshire Drive, Fallston, MD 21047</b>  |   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>[Signature]</i>                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Cemetery</b>  | Date<br><b>May 11 2012</b>  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  | 22. Name and Address of Facility<br><b>Stallings Funeral Home, P.A.<br/>3111 Mountain Road, Pasadena, MD 21122</b>  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Head Injuries</b> |   |   |  |  | Approximate Interval Between Onset and Death   |  |
|  | Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   |   |   |  |  |  |  |
|  | <input type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED  | #1perME, G927, 5/11/2012, WS  |   |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year                                |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene           |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide            | 28a. Date of Injury (Month, Day, Year)<br><b>May 5, 2012</b>  | 28b. Time of Injury<br><b>0225 hrs</b>  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                              | 28d. Describe how injury occurred<br><b>Driver auto auto collision</b> |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) <b>Interstate/Express</b>  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>695 prior to Route 2, Glen Burnie, MD</b> |  |  |  |
|  | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner:  | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                       |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br><i>[Signature]</i>  | 29c. License number<br><b>O.C.M.E.</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 5, 2012</b>              |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |   |   |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |

**Division of Vital Records, P.O. Box 68760,****To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3

OCME

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|                        |   |  |   |  |  |  |
|------------------------|---|--|---|--|--|--|
| <b>State Registrar</b> | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b> |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |  |
| ORIGINAL               |   |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15108

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|
| <b>Physician/<br/>Medical Examiner</b>     |  | 1- For State<br>Registrar   |  |   |  |   |  | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death<br>0643 hrs   |  |  |  |  |  |  |  |
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Diane M. Whitman</b>   |  |   |  |   |  | 4a. Facility Name (if not institution, give street and number)<br>Route 108 at Zion Road   |  | 4b. City, Town, or Location of Death<br>Olney  |  |  |  |  |  |  |  |
| <b>Funeral<br/>Director</b>                |  | 4a. Facility Name (if not institution, give street and number)<br>Route 108 at Zion Road  |  | 4b. City, Town, or Location of Death<br>Olney   |  | 4c. County of Death<br>Montgomery   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 5. Social Security Number<br><b>201-48-3737</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b><br>Yrs.   |  | If Under 1 Year<br>Months Days Hours Min.  |  | 8. Date of Birth (MM/DD/YYYY)<br><b>10/1/1963</b>  |  | 9. Birthplace (State or<br>Foreign Country)<br>PA  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b> |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>  |  |   |  |   |  | 10b. County<br><b>Montgomery</b>   |  |  |  |  |  | 10c. City, Town or Location<br><b>Montgomery Village</b> |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 10e. Street and Number<br><b>9853 Sailfish Tr</b>   |  |   |  |   |  | 10f. Zip Code<br><b>20886</b>  |  |  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>              |  |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:<br><b>white</b> |  | 14. Race - American Indian, Black, White, etc.   |  |  |  |  |  |  |  |  |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Bio-Tech</b>  |  | 16b. Kind of Business/Industry<br><b>Medical</b>  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Paul Meehan</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleanor Burke</b>  |  |  |  |  |  |  |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Micahel Whitman, husband</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>245 Boland Ave Hanover Twp PA 18706</b>  |  |  |  |  |  |  |  |  |  |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maple Hill Crematory</b>   |  | Date<br><b>5/9/2012</b>   |  | 20c. Location - City or Town, State<br><b>Hanover PA</b>   |  |  |  |  |  |  |  |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>TBW</b>   |  | 22. Name and Address of Facility<br><b>Harman Funeral Service PA<br/>7221 Grayburn Dr Glen Burnie MD 21061</b>  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>Physician/<br/>Medical Examiner</b>     |  | 23a. Part I. Enter all disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | a. Multiple Injuries<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | <input type="checkbox"/> UNPENDED   |  | <input type="checkbox"/> AMENDED  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |  |  |  |  |  |
|  |  | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other, Scene         |  |   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>May 3, 2012</b>   |  | 28b. Time of Injury<br>0629 hrs   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Bicyclist struck by a vehicle</b>  |  |  |  |  |  |  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br><b>Local Street</b>  |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Route 108 at Zion Road, Olney, MD</b> |  |  |  |  |  |  |  |
|  |  | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 29b. Signature and title of certifier<br><b>hjw</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 4, 2012</b>   |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>State<br/>Registrar</b>                 |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne A. Parker</b>  |  |   |  |  |  |  |  |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15109

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

|   |  |   |                                     |   |                                     |
|---|--|---|-------------------------------------|---|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |                                     | 3. Time of Death<br>1509 M  |                                     |
| <i>Loretta Willits</i>  |  | BALTIMORE   |                                     |   |                                     |
| 4a. Facility Name (if not institution, give street and number)<br><i>Frankford NSG &amp; Rehab</i>  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |                                     | 4c. County of Death   |                                     |
| 5. Social Security Number<br><b>212-28-8059</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F<br>81 Yrs.   |                                     | 7. Age (In yrs. last birthday)<br>If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>FEB 8, 1931</b>   |                                     |
| 10a. State<br><b>MD</b>   |  | 10b. County   |                                     | 10c. City, Town or Location<br><b>Baltimore</b>   |                                     |
| 10e. Street and Number<br><b>5009 Frankford Avenue</b>  |  | 10f. Zip Code<br><b>21206</b>   |                                     | 10g. Citizen of What Country?<br><b>USA</b>   |                                     |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>white</b> |                                     |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>5+</b>  |                                     | 16b. Kind of Business Industry<br><b>unk</b><br><b>US Government</b>  |                                     |
| 17. Father's Name (First, Middle, Last)   |  | unk   |                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Kosinski-Antczak</b>  |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Monica Willits/daughter in law</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5585 Washington Avenue Menpor, OH 44060</b>   |                                     |   |                                     |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                     | Date  | 20c. Location - City or Town, State |
| 21. Signature of Funeral Director<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>  |                                     |   |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | a. <i>CARDIOPATHY</i><br>Due to (or as a consequence of):   |                                     | Approximate Interval Between Onset and Death  |                                     |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | b. Due to (or as a consequence of):   | c. Due to (or as a consequence of): | d. Due to (or as a consequence of):   |                                     |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                                     | 23d. Date of delivery<br>Month Day Year   |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DENTAL</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                                     |   |                                     |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                     |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                     |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>R158,40</b>   |                                     | 29d. Date signed (Month, Day, Year)<br><b>5/2/2012</b>  |                                     |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>8813 Waltham Woods Rd Ste 204 Parkville, MD 21234</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |                                     | 32. Registrar's Signature<br><b>Leanne J. Parker</b>  |                                     |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15110

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  |  |  | 3. Time of Death   |  |
| <b>MATTIE WILLIAMS</b>   |  | 05/08/2012  |  |  |  | 9:07 AM  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Future Care Sand Town</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |  |  | 4c. County of Death<br><b>USA</b>  |  |
| 5. Social Security Number<br><b>125 32-9023</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>94</b> Yrs.   |  | 8. If Under 1 Year<br>Months Days Hours Min.   |  |
| Usual Residence of Decedent<br><b>N/A</b>  |  |   |  |  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>07/17/1917</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>USA</b>   |  |   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1000 N. Gilmore St.</b>   |  |   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:       |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                            |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>PRESSOR</b>  |  | 16b. Kind of Business/Industry<br><b>Dry Cleaners</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>UNK</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNK</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MATTIE WHITE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number-City or Town, State, Zip Code)<br><b>229 N. MOUNT ST. Apt. 309 BALTIMORE MD 21223</b>   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>MED</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MED</b>  |  | Date<br><b>5-12-12</b>   |  | 20c. Location - City or Town, State<br><b>CATONSVILLE MD</b>                                       |  |
| 21. Signature of Funeral Service Licensee<br><b>▶ MARY J. MARCH</b>  |  | 22. Name and Address of Facility<br><b>GARY P. MARCH FUNERAL HOME 21229 BALTIMORE MD</b>  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. Due to (or as a consequence of):<br><b>Advanced Dementia</b>   |  |  |  | Approximate Interval Between Onset and Death   |  |
|  |  | b. Due to (or as a consequence of):<br><b>Atherosclerotic Cardiovascular Disease</b>  |  |  |  |  |  |
|  |  | c. Due to (or as a consequence of):   |  |  |  |  |  |
|  |  | d. Due to (or as a consequence of):   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | Other:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  |  |   |  |  |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |
| 29b. Signature and title of certifier<br><b>▶ Nazir Al</b>   |  |   |  | 29c. License number<br><b>047405</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/12</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LIAQAT ALI 821-N- Eutaw St. Baltimore MD 21201</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Suzanne S. Farakal</b>  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15111

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |   |  |  |  |   |  |  |  |                                    |  |  |  |
|--|--|---|--|--|--|---|--|--|--|------------------------------------|--|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>NATHAN ZABA</b>  |  |  |  |   |  | 2. Date of Death<br>Month <b>May</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>2004P M</b> |  |  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 4a. Facility Name (if not institution, give street and number)<br><b>atrium village</b>   |  |  | 4b. City, Town, or Location of Death<br><b>OWINGS MILLS</b>  |   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |                                    |  |  |  |
| Funeral<br>Director  |  | 5. Social Security Number<br><b>213-14-9555</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> X M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/20/1921</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |                                    |  |  |  |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>OWINGS MILLS</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                    |  |  |  |
|  |  | 10e. Street and Number<br><b>4730 ATRIUM COURT, #478</b>  |  |  | 10f. Zip Code<br><b>21117</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                    |  |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |                                    |  |  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) OWNER</b>   |  | 16b. Kind of Business/Industry<br><b>GROCERY STORE</b>  |  |  |  |                                    |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>ISAAC ZABA</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATIE KLAVANS</b>  |   |  |  |  |                                    |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SANDY GOLDBERG/DAUGHTER</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 HIGH KNOB LANE, REISTERSTOWN, MD 21136</b> |   |  |  |  |                                    |  |  |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>BETH TFILOH CONGR.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date<br><b>05/10/2012</b>   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |  |  |                                    |  |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>► 19</b>  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>   |  |   |  |  |  |                                    |  |  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Atherosclerotic Cardiovascular Disease</b>   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |                                    |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | a. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b>   |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | b. Due to (or as a consequence of):   |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | c. Due to (or as a consequence of):   |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | d. _____  |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____ |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |                                    |  |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                                    |  |  |  |
|  |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |  |  |  |
|  |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                                    |  |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>Aerodentlevina</b> |  |  |                                    |  |  |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |                                    |  |  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |                                    |  |  |  |
|  |  | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | 29b. Signature and title of certifier<br><b>► Harold Bob</b>  |  | 29c. License number<br><b>D15872</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b>  |  |  |                                    |  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harold Bob 6934 Aviation Blvd Glen Burnie 21061</b>  |  |  |  |   |  |  |  |                                    |  |  |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Senia J. Parks</b>   |  |   |  |  |  |                                    |  |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15112

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|  |  |   |  |  |  |   |   |  |  |  |
|--|--|---|--|--|--|---|---|--|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Rita Catherine Byard</b>   |  |  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 22, 2012</b>  |  | 3. Time of Death<br><b>2030 hrs</b>              |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>   |  |  |  |   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>         |
|  |  | 5. Social Security Number<br><b>205-16-2513</b>   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>87</b>  | If Under 1 Year<br>Months<br><b>Yrs.</b>   | If Under 24Hrs.<br>Hours<br><b>Min.</b>   | 8. Date of Birth (MM/DD/YYYY)<br><b>July 23, 1924</b> | 9. Birthplace (State or Foreign)<br><b>Pennsylvania</b>  |  |  |
|  |  | Usual Residence of Decedent<br>10a. State<br><b>Maryland</b>  |  |  |  |   |   | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Emmitsburg</b> |
|  |  | 10e. Street and Number<br><b>308 S. Seton Avenue</b>  |  |  |  |   |   | 10f. Zip Code<br><b>21727</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>      |
|  |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify:<br><b>white</b> | 14. Race - American Indian, Black, White, etc.<br><b>white</b>   |   |   |  |  |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Secretary</b>  | 16b. Kind of Business/Industry<br><b>Church</b>  |  |   |   |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Oliver Sanders</b>  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Ryder</b>   |  |  |   |   |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Terence Byard, son</b>   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1012 Columbia Road, Hagerstown, MD 21742</b>   |  |  |   |   |  |  |  |
|  |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New St Joseph's Cem</b>   | Date<br><b>4/26/2012</b>   | 20c. Location - City or Town, State<br><b>Emmitsburg, MD</b>   |   |   |  |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Jester R. D. Durborsaw</b>  | 22. Name and Address of Facility<br><b>Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727</b>   |  |  |   |   |  |  |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Head Injuries</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br><b><input type="checkbox"/> UNPENDED      <input type="checkbox"/> AMENDED</b> |  |  |  |   |   | Approximate Interval Between Onset and Death   |  |  |
|  |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b><br><b>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)</b><br><b>9 <input type="checkbox"/> Unknown</b> | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |  |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |  |
|  |  | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:</b>                 |  |  |   |   |  |  |  |
|  |  | 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b><br><b>2 <input checked="" type="checkbox"/> Accident</b><br><b>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined</b><br><b>4 <input type="checkbox"/> Homicide</b>  | 28a. Date of Injury (Month Day Year)<br><b>Apr 14, 2012</b>  | 28b. Time of Injury<br><b>1800 hrs</b>   | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | 28d. Describe how injury occurred<br><b>Subject fell</b>  |   |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>(Specify) Single Family Home</b>   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>308 S. Seton Avenue, Emmitsburg, MD</b>  |   |  |  |  |
|  |  | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  |  |  |  |   |   |  |  |  |
|  |  | 29b. Signature and title of certifier<br><b>M. Brassell, MD</b>   |  |  |  |   |   | 29c. License number<br><b>O.C.M.E.</b>   |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |  |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>   |  |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |  |  | 32. Registrar's Signature<br><b>Leanne B. Parker</b>   |   |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 18 per FH FCHD TM 5/1/2012

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15113

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

10  
State  
Registrar

|   |  |  |  |   |
|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death  |
| BETTY SAWYERS BURDETTE  |  | APRIL 22 2012  |  | 11:25 AM  |
| 4a. Facility Name (if not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |  | 4c. County of Death<br><b>FREDERICK</b>   |
| 5. Social Security Number<br><b>217-28-1141</b><br>Usual Residence of Decedent  |  | 6. Sex<br><b>1 □ M 2 X F</b>   | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b> | If Under 1 Year<br>Months Days Hours Min.<br>If Under 24 Hrs.   |
| 10a. State<br><b>Florida</b>  |  | 10b. County<br><b>Pasco</b>  |  | 10c. City, Town or Location<br><b>Zephyrhills</b>   |
| 10e. Street and Number<br><b>5502 Braddock Drive</b>  |  | 10f. Zip Code<br><b>33541</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |
| 11. Marital Status<br><b>1 □ Never Married 2 □ Married<br/>3 X Widowed 4 □ Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No<br/>If Yes, Give Year or Dates.</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Owner/Hairstylist</b>   |  | 16b. Kind of Business/Industry<br><b>Beauty Salon</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Edwin Kyle Sawyers</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Katherine Fry</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Darron Long / Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26334 Ridge Road, Damascus, Maryland 20872</b>   |  |   |
| 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Damascus Church Cemetery</b>  |  | Date<br><b>4/26/2012</b>  |
| 21. Signature of Funeral Service Licensed<br><i>Todd O'Leary</i>  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes P. A.<br/>1621 Opossumtown Pike, Frederick, Maryland 21702</b>   |  | 20c. Location - City or Town, State<br><b>Damascus, Maryland.</b>   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | Approximate Interval Between Onset and Death<br><b>4 days</b>   |
| 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b>  |  | 23d. Date of delivery<br>Month Day Year  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>  |  |  |  |   |
| 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>   |  |   |
| 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other:<br><b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>  |  |   |
| 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide<br/>4 □ Homicide</b>   |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>M</b>  | 28b. Time of injury<br><b>M</b>                  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |
|   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D09689</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/23/12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Austin Pearre MD 300 West 9th Street, Frederick, Maryland 21701</b>  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |  | 32. Registrar's Signature<br><i>Austin J. Pearre</i>   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item 1- For State Registrar #19a, per F.H., 4/30/12 BA Certificate of Death WCHD

Reg. No. 2012 15114

|                                     |   |  |   |   |   |  |  |  |
|-------------------------------------|---|--|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Louis Wilson Birch, Jr.</b>  |  |   | 2. Date of Death<br>Month 4 Day 25 Year 2012                              | 3. Time of Death<br>11:48 P M   |  |  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>9734 Bishopville Rd.</b>   |  | 4b. City, Town, or Location of Death<br><b>Bishopville</b>  |   | 4c. County of Death<br><b>Worcester</b>   |  |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>214-46-4059</b>   | 6. Sex<br><input checked="" type="checkbox"/> X M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.   |  |  |  |
|                                     | 8. Date of Birth<br>(Month, Day, Year)<br><b>7/1/1948</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |   |  |  |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Worcester</b> 10c. City, Town or Location<br><b>Bishopville</b>  |  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|                                     | 10e. Street and Number<br><b>9734 Bishopville Rd.</b>   |  | 10f. Zip Code<br><b>21813</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>white</b> |  |  |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>  |   | 16b. Kind of Business Industry<br><b>Maintenance</b>  |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Louis Wilson Birch, Sr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Lily Day</b> |   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Birch / wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9734 Bishopville Rd., Bishopville, MD 21813</b>   |   |   |  |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>First State Crem.</b>  |   | Date<br><b>4/27/12</b>  | 20c. Location - City or Town, State<br><b>Millsboro, DE</b>  |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Burbage Funeral Home 108 William St., Berlin, MD 21811</b>   |   |   |  |  |  |
| Physician/<br>Medical<br>Examiner   | 23a. Part I. Enter the cause, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COPD</b>   |  |   |   |   | Approximate Interval Between Onset and Death   |  |  |
|                                     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |   |  |  |  |
|                                     | <p>a. Due to (or as a consequence of):<br/><b>COPD</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |   |   |  |  |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |  |  |
|                                     |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |
|                                     | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>H44828</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>4/27/12</b>  |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brookellen Riden, D.O. 314 Franklin Ave. Berlin MD 21811</b>   |  |   |   |   |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>APR 27 2012</b>   |  | 32. Registrar's Signature<br>  |   |   |  |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15115

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>0608 hrs |
| MICHAEL WAYNE BRACEY                     |                                    | May 2, 2012                  |

**Funeral Director**

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 4a. Facility Name (if not institution, give street and number)<br>Southern Maryland Hospital | 4b. City, Town, or Location of Death<br>Clinton                            | 4c. County of Death<br>Prince George's    |   |   |   |
| 5. Social Security Number<br>228-82-5404   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>57 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>1-5-1955 | 9. Birthplace (State or Foreign Country)<br>WASH., D.C. |

**To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |   |   |  |
|--|---|---|--|
| 10a. State<br>MD.  | 10b. County<br>CHARLES  | 10c. City, Town or Location<br>WALDORF  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>3376 OLD WASHINGTON ROAD   | 10f. Zip Code<br>20602  | 10g. Citizen of What Country?<br>U.S.A.   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:<br>Specify: WHITE | 14. Race - American Indian, Black, White, etc.   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)                      | 16b. Kind of Business/Industry<br>ENVIRONMENTAL INSPECTOR   | PRINCE GEORGES CO. BOARD OF EDUCATION  |
| 17. Father's Name (First, Middle, Last)<br>WILLIAM FLOYD BRACEY  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LAURA LOU WATHEN   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>DEBRA D. BRACEY-SPOUSE   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3376 OLD WASH. RD. WALDORF, MD 20602                 | Date  | 20c. Location - City or Town, State<br>ALEX., VA.  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br>METROPOLITAN CREMATORIAL | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   |  |
| 21. Signature of Funeral Service Licensee<br>M00479  | 22. Name and Address of Facility<br>RAYMOND FUNERAL SERVICE P. A.<br>LA PLATA, MARYLAND 20646   |   |  |

**Physician/  
Medical Examiner**

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. Multiple Injuries<br>Due to (or as a consequence of):   |  |
| b.   |  |
| c.   |  |
| d.   |  |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED   |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Division of Vital Records, P.O. Box 68760,**

|  |   |   |
|--|---|---|
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|

|   |  |  |   |   |
|---|--|--|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>FOUND: May 2, 2012   | 28b. Time of Injury<br>FOUND: 0500 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Subject driver of motor vehicle involved in motor vehicle accident                       |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Major Road / Highway |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Route 301 North of Dyson Road, Brandywine, MD |

|   |
|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

|   |                                      |  |
|---|--------------------------------------|--|
| 29b. Signature and title of certifier<br>Theodore M. King, Jr., MD. | 29c. License number<br>O.C.M.E. OCME | 29d. Date signed (Month, Day, Year)<br>May 3, 2012 |
|---|--------------------------------------|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|--|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012 | 32. Registrar's Signature<br>Lorraine A. Farrel |
|--|---|

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15116

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Physician/  
Medical  
Examiner

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death  |
| <b>Hugh Clayton Clem</b>   |  | <b>April 24 2012 132P M</b>   |   | <b>132P M</b>   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death   |
| <b>Copper Ridge</b>  |  | <b>Sykesville</b>   |   | <b>Carroll</b>  |
| 5. Social Security Number  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88 Yrs.</b>                | If Under 1 Year<br>Months Days Hours Min.   |
| <b>219-12-0293</b>   |  |   |   |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>   | 10c. City, Town or Location<br><b>Mt. Airy</b>                  |   |
| 10e. Street and Number<br><b>818 Ferris Wheel Lane</b>   |  | 10f. Zip Code<br><b>21771</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1943-46</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br><b>manager</b>  |   | 16b. Kind of Business Industry<br><br><b>Grocery</b>  |
| 17. Father's Name (First, Middle, Last)<br><br><b>Raymond Clem</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname) <b>(unk.)</b>   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><br><b>Lillian Clem/wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br><b>818 Ferris Wheel Lane, Mt. Airy, MD 21771</b>   |   |   |
| 20a. Method of Disposition<br><br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><br><b>Resthaven Mem. Gar.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br><b>Resthaven Mem. Gar.</b>  | Date<br><b>04/28/2012</b>                                       | 20c. Location - City or Town, State<br><br><b>Frederick, MD</b>   |
| 21. Signature of Funeral Service Licensee<br><br><b>Asley C. Meier</b>   |  | 22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A.</b><br><br><b>1621 Opossumtown Pike, Frederick, MD 21702</b>   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><br><b>years</b>  |   |   |
| <p>a. Due to (or as a consequence of):<br/><br/><b>End stage dementia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Leukemia</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |
|  |  | <p>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>                                   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28d. Describe how injury occurred                               |   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br><b>Carrie Wheeler CRNP</b>   |   |   |
|  |  | 29c. License number<br><b>R194787</b>   | 29d. Date signed (Month, Day, Year)<br><br><b>April 24 2012</b> |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><br><b>Carrie Wheeler CRNP</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |   |   |
|  |  | 32. Registrar's Signature<br><br><b>Brian B. Jardine</b>  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15117

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|  |  |   |                                |  |   |  |      |  |   |  |   |
|--|--|---|--------------------------------|--|---|--|------|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  |   |                                | 2. Date of Death   |   |  |      | 3. Time of Death   |   |  |   |
| NICHOLAS GUS CONSTANTINE   |  |   |                                | Month April Day 16 Year 2012   |   |  |      | 1:05 AM  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)   |  |   |                                | 4b. City, Town, or Location of Death   |   |  |      | 4c. County of Death  |   |  |   |
| Frederick Memorial Hospital  |  |   |                                | Frederick  |   |  |      | Frederick  |   |  |   |
| 5. Social Security Number  |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year  |   | If Under 24 Hrs.   |      | 8. Date of Birth (Month, Day, Year)                              |   | 9. Birthplace (State or Foreign Country)   |   |
| 177-05-1037  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 93 Yrs.                        | Months   | Days  | Hours  | Min. | Feb 16, 1919   |   | Colorado   |   |
| 10a. State   |  | 10b. County   |                                | 10c. City, Town or Location  |   |  |      |  |   | 10d. Inside City Limits  |   |
| Maryland   |  | Frederick   |                                | Walkersville   |   |  |      |  |   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 10e. Street and Number   |  |   |                                | 10f. Zip Code  |   |  |      | 10g. Citizen of What Country?                                    |   |  |   |
| 56 W. Frederick Street   |  |   |                                | 21793  |   |  |      | USA  |   |  |   |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |      | 14. Race - American Indian, Black, White, etc.<br>Specify: white |   |  |   |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   |                                |  |   |  |      |  |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)  |  |   |                                | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |   |  |      | 16b. Kind of Business/Industry                                   |   |  |   |
| Elementary/Secondary (0-12) 12   |  | College (1-4 or 5+)   |                                | Chef/Manager   |   |  |      | Restaurant   |   |  |   |
| 17. Father's Name (First, Middle, Last)<br>Gus Nicholas Constantine  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Vasiliki Bouzanis   |   |  |      |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Felicia Constantine - daughter   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11129 Pond Fountain Court, New Market, Maryland 21774 |   |  |      |  |   |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cheltenham Veterans  |   |  |      | Date   | 20c. Location - City or Town, State<br>Cheltenham, Maryland |  |   |
| 21. Signature of Funeral Service Licensee<br>Sharon Lamille Celene   |  |   |                                | 22. Name and Address of Facility<br>Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702   |   |  |      |  |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                |  |   |  |      |  |   | Approximate Interval Between Onset and Death   |   |
| Immediate Cause (Final disease or condition resulting in death)<br><br>C. Substantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |                                |  |   |  |      |  |   | <i>Sept's</i>  |   |
| <p>a. Due to (or as a consequence of):<br/><i>Coronary Artery Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |                                |  |   |  |      |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                |  |   | 23d. Date of delivery<br>Month Day Year                                      |      |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |  |   |  |      |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
|  |  |   |                                |  |   |  |      |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)           |                                |  |   |  |      |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |                                | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |      |  |   |  |   |
|  |  |   |                                |  |   |  |      |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |      |  |   |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |   |  |      |  |   |  |   |
| 29b. Signature and title of certifier<br><i>J. Lee, MD</i>   |  | 29c. License number<br><i>D60417</i>  |                                |  |   | 29d. Date signed (Month, Day, Year)<br><i>4-16-2012</i>                      |      |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Hemen Shah, 65c Thomas Johnson Dr, Frederick MD 21702</i>   |  |   |                                |  |   |  |      |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><i>APR 26 2012</i>  |  | 32. Registrar's Signature<br><i>James S. Park</i>   |                                |  |   |  |      |  |   |  |   |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15118

1- For State Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

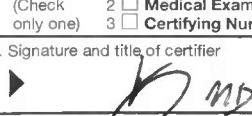
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 4 Day 24 Year 2012  |   | 3. Time of Death<br>5:11 PM  |
| Alan Randall Callaway  |  | 4b. City, Town, or Location of Death<br>Berlin  |   | 4c. County of Death<br>Worcester   |
| 4a. Facility Name (if not institution, give street and number)<br>Atlantic General Hospital  |  | 4b. City, Town, or Location of Death<br>Berlin  |   | 4c. County of Death<br>Worcester   |
| 5. Social Security Number<br>215-62-1312   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>59 Yrs.   | If Under 1 Year<br>Months Days Hours Min.<br>8/12/1952                               |
| Usual Residence of Decedent  |  | 10a. State<br>MD 10b. County<br>Worcester 10c. City, Town or Location<br>Berlin   |   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>619 William St. 10f. Zip Code<br>21811 10g. Citizen of What Country?<br>USA   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) 12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Solid Waste Division  | 16b. Kind of Business Industry<br>Worcester County  |  |
| 17. Father's Name (First, Middle, Last)<br>John Callaway   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Hill  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Theresa Litten / daughter  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7628 Downs Rd., Newark, MD 21841   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Riverside Cem.  | Date<br>4/28/2012   | 20c. Location - City or Town, State<br>Libertytown, MD                               |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Burbage Funeral Home<br>108 William St., Berlin, MD 21811   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><i>Myocardial Infarction</i>  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28d. Describe how injury occurred   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D58106   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br>4/26/2012  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William E Gunn 10445 Ocean City Blvd Berlin, MD 21811  |  | 31. Date filed (Month, Day, Year)<br>APR 27 2012  |   |  |
| 32. Registrar's Signature<br>   |  |   |   |  |

ORIGINAL

BA 15

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items 25, 23a Pt II per me, g927, 05/23/2012dhp Certificate of Death

Reg. No. 2012 15119

|  |   |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
|--|---|--|---|---|---|---|---|---|--|--|---|--|--|-----------------------------------|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>James Cooper</b>   |  |   |   | 2. Date of Death<br>Month 4 Day 23 Year 2012  | 3. Time of Death<br>5:15 p M                                      |   |   |  |  |   |  |  |                                   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>6030 Sargent Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>  |   | 4c. County of Death<br><b>Prince Georges</b>  |   |   |   |  |  |   |  |  |                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-34-7202</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. 84   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-5-1927</b>         | 9. Birthplace (State or Foreign Country)<br><b>DC</b> |   |  |  |   |  |  |                                   |  |  |
|  | Usual Residence of Decedent<br><b>MD Prince Georges</b>   |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Prince Georges</b>  |   | 10c. City, Town or Location<br><b>Hyattsville</b>     |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |                                   |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>6030 Sargent Road</b>  |  |   | 10f. Zip Code<br><b>20782</b>   |   |   | 10g. Citizen of What Country?<br><b>United States</b> |   |  |  |   |  |  |                                   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |   |  |  |                                   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Clerk</b>  |   | 16b. Kind of Business/Industry<br><b>Government</b>   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Oscar Newman</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lossie Ellis</b>  |   |   |   |  |  |   |  |  |                                   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Cooper/Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6030 Sargent Rd. Hyattsville MD 20782</b> |   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>M01592</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln</b>   |   | Date<br><b>5-1-2012</b>   | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b> |   |   |  |  |   |  |  |                                   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Reinoell</b>  |  | 22. Name and Address of Facility John T. Rhines Funeral Home<br><b>3005 12th Street NE Washington DC 20017</b>  |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):  |  |   |   |   |   |   |   | Approximate Interval Between Onset and Death   |  |   |  |  |                                   |  |  |
|  | b. <b>Arteriosclerosis</b><br>Due to (or as a consequence of):  |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | c. <b>Hypertension</b><br>Due to (or as a consequence of):  |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | d. _____  |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____                                 |   |   |   |   |   | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |                                   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>1. Parkinsonism 2. Previous Subdural Hematoma</b><br><b>Many Years Ago 3. Hypercholesterolemia</b>   |  |   |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |  |                                   |  |  |
|  |   |  |   |   |   |   |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |                                   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   |   |   |  |  | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |
|  |   |  |   |   |   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                   |  |  |
|  | 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |   |   |   | 29c. License number<br><b>D24593</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-26-2012</b>   |  |  |                                   |  |  |
|  | 29b. Signature and title of certifier<br><b>Mohammed A. Mannah</b>  |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mohammed A. Mannah, MD 3331 Toledo Terrace Hyattsville MD. 20782</b>   |  |   |   |   |   |   |   |  |  |   |  |  |                                   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br><b>Susan J. [Signature]</b>  |   |   |   |   |   |  |  |   |  |  |                                   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

# 23 PGS  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15120

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| LINDA A. ELLIS                           | APRIL 22, 2012                     | 7:15 AM          |

|  |                                      |                     |
|--|--------------------------------------|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| 7235 COOPER POINT ROAD   | BOZMAN                               | TALBOT              |

Funeral  
Director

|                           |  |                                |   |  |  |
|---------------------------|--|--------------------------------|---|--|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| 149-30-7856               | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 72 Yrs.                        |   | APRIL 6, 1940                          | NEW JERSEY                               |

Usual Residence of Deceased  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|            |             |                             |  |
|------------|-------------|-----------------------------|--|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| MD         | TALBOT      | BOZMAN                      |  |

|                        |               |                               |
|------------------------|---------------|-------------------------------|
| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| 7235 COOPER POINT ROAD | 21612         | USA                           |

|  |   |   |  |
|--|---|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |
|--|---|---|--|

|  |  |   |
|--|--|---|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) 3 EDITOR | 16b. Kind of Business/Industry<br>NEWSPAPER |
|--|--|---|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br>DALE VAN OSTEN | 18. Mother's Name (First, Middle, Maiden Surname)<br>DOROTHY BROWN |
|---|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>WILLIAM G. ELLIS, JR., HUSBAND | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7235 COOPER POINT ROAD, BOZMAN, MD 21612 |
|--|---|

|   |  |      |   |
|---|--|------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CHESAPEAKE CREMATION | Date | 20c. Location - City or Town, State<br>STEVENSVILLE, MD |
|---|--|------|---|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br>FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.<br>200 SOUTH HARRISON STREET, EASTON, MD 21601 |
|--|--|

|  |                                 |   |
|--|---------------------------------|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Chronic myelomonocytic leukemia | Approximate Interval Between Onset and Death<br>Years |
| a. Due to (or as a consequence of):  |                                 |   |
| b. Due to (or as a consequence of):  |                                 |   |
| c. Due to (or as a consequence of):  |                                 |   |
| d. Due to (or as a consequence of):  |                                 |   |

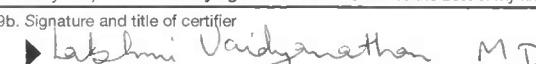
|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |  |
|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|--|

|  |  |                          |  |  |
|--|--|--------------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |
|--|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|--|

|  |                                 |   |
|--|---------------------------------|---|
| 29b. Signature and title of certifier<br> | 29c. License number<br>DO 57749 | 29d. Date signed (Month, Day, Year)<br>April 25, 2012 |
|--|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>LAKSHMI VAIDYANATHAN 219 S. WASHINGTON ST, EASTON, MD - 21601 |
|---|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>APR 25 2012 | 32. Registrar's Signature<br> |
|--|--|

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

125  
12

State  
Registrar

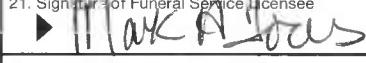
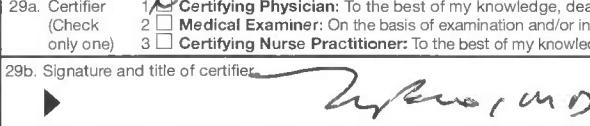
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15121

1- For  
State  
Registrar

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Harriet Elizabeth Ellis</b>   |   |   |  |  | 2. Date of Death<br><b>4-21-2012</b>   | 3. Time of Death<br><b>3:05am</b>                          |  |
|  |  |   |   |  |  | M  |  |  |
| <b>Funeral<br/>Director</b>  | 4a. Facility Name (if not institution, give street and number)<br><b>Carriage Hill Nursing Home</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |
|  | 5. Social Security Number<br><b>058-26-1912</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b>   | If Under 1 Year<br>Months<br><b>0</b>  | If Under 24 Hrs.<br>Hours<br><b>0</b>  | Min.<br><b>0</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>3-07-1926</b> | 9. Birthplace (State or Foreign Country)<br><b>New York, NY</b>                                |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Bethesda</b>  |  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>5215 West Cedar Lane</b>  |   |   | 10f. Zip Code<br><b>20814</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>      |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Assistant</b>  |  |  | 16b. Kind of Business/Industry<br><b>Defense Mapping Agency</b>  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   | 17. Father's Name (First, Middle, Last)<br><b>George Tyson</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marguerite Adelaide Skirvin</b>  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Picasso/ Daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5204 Oakland Rd, Chevy Chase, MD 20815</b> |  |  |  |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>   |  |  | Date<br><b>May 1, 2012</b>                                 | 20c. Location - City or Town, State<br><b>Portsmouth, RI</b>                                   |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   | 22. Name and Address of Facility <b>Joseph Gawler's Sons, INC</b><br><b>5130 Wisconsin Ave, N.W. Washington DC 20016</b>                       |  |  |  |  |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Due to (or as a consequence of): <b>Dementia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death</p>  |  |   |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>   |  |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |  |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br><b>00057124</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>  |  |  |
| <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br/><b>Truong Bao, M.D.</b> <b>8600 Old Georgetown Rd, Bethesda, MD 20814</b></p>  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  |   | 32. Registrar's Signature<br>  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit.

6

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15122

1 - For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|  |  |  |                                |   |                                     |
|--|--|--|--------------------------------|---|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)   |  | DARRELL LLOYD FORD   |                                | 2. Date of Death  | 3. Time of Death                    |
| 4a. Facility Name (if not institution, give street and number)   |  | HOWARD COUNTY GENERAL  |                                | Month APR   | Day 27 Year 2012                    |
| 5. Social Security Number  |  | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months      Days      Hours      Min.  |                                     |
| 232-68-4181  |  | <input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 70 Yrs.                        |   |                                     |
| Usual Residence of Decedent  |  | 10c. City, Town, or Location   |                                | 8. Date of Birth<br>(Month, Day, Year)  |                                     |
| MD Howard  |  | Ellicott City  |                                | March 21, 1942  |                                     |
| 10e. Street and Number   |  | 10f. Zip Code  |                                | 9. Birthplace (State or Foreign Country)  |                                     |
| 3725 Valley Road   |  | 21042  |                                | Ohio  |                                     |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     |
| <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                    |                                     |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |                                | 16b. Kind of Business/Industry  |                                     |
| Elementary/Secondary (0-12)  |  | College (1-4 or 5+)  |                                | Distribution Operations Mgr Lennox Industries   |                                     |
| 2  |  | 2  |                                |   |                                     |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |                                |   |                                     |
| Garland Oral Ford  |  | Oma Janet Hickman  |                                |   |                                     |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                                |   |                                     |
| Roxann Neuman Ford/wife  |  | 3725 Valley Road Ellicott City, Maryland 21042   |                                |   |                                     |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                | Date  | 20c. Location - City or Town, State |
| <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | Ardent Cremation Svc.  |                                | 5/1/2012  | Hanover, Maryland                   |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility   |                                | Harry H. Witzke's Family FH Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043                              |                                     |
| Quanta R Thomas  |  |  |                                |   |                                     |
| 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  | Approximate Interval Between Onset and Death   |                                |   |                                     |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. Due to (or as a consequence of): RESPIRATORY FAILURE  |                                |   |                                     |
| B. Subsequently list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. Due to (or as a consequence of): CARDIO PULMONARY ARREST  |                                |   |                                     |
|  |  | c. Due to (or as a consequence of): HYPERCALEMIA   |                                |   |                                     |
| d.   |  |  |                                |   |                                     |
| IF FEMALE:   |  | 23c. If yes, outcome of pregnancy  |                                | 23d. Date of delivery   |                                     |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |                                | Month   | Day                                 |
|  |  |  |                                | Year  |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?   |                                |   |                                     |
| CHRONIC RIGHT LEG CELLULITIS<br>DIABETES MELLITUS  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                |   |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)  |                                |   |                                     |
| Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                                |   |                                     |
| 27. Manner of Death  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                | 28d. Describe how injury occurred   |
| <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | M  |                                |   |                                     |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                    |                                     |
| 29a. Certifier<br>(Check only one)   |  | 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                | 29d. Date signed (Month, Day, Year)   |                                     |
| 29b. Signature and title of certifier  |  | D 0064539  |                                | APR 27 2012   |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  | 32. Registrar's Signature  |                                |   |                                     |
| SRILATHA KANUMURU, 5755 CEDAR LANE, COLUMBIA, MD.  |  | Anna P. Parker   |                                |   |                                     |
| 31. Date filed (Month, Day, Year)  |  | 33. Registrar's Signature  |                                |   |                                     |
| APR 30 2012  |  |  |                                |   |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend per FCHD 4/26/12

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15123

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |   |
|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen Marie Waters Gladhill</b>   |  | 2. Date of Death<br>Month 4 Day 22 Year 2012   | 3. Time of Death<br>8:30P M   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Glade Valley Nursing Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Walkersville</b>  |   |
| 4c. County of Death<br><b>Frederick</b>  |  |  |   |
| 5. Social Security Number<br><b>216-46-7950</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>95 Yrs.   |
| 8. Usual Residence of Decedent<br><b>MD Frederick</b>  |  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>  |   |
| 10c. City, Town or Location<br><b>Middletown</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>34 E. Green St.</b>   |  | 10f. Zip Code<br><b>21769</b>  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>5+</b><br><b>director</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Guy P. Waters</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Younkins</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Ray Romane (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6401 Manor Woods Rd., Frederick, MD 21703</b>  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lutheran Cemetery</b>   | Date<br><b>4/25/2012</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Donald B. Thompson Funeral Home</b><br><b>POB 18, Middletown, MD 21769</b>  |   |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)  |  |  |   |
| a. Due to (or as a consequence of):<br><b>Pneumonia</b>  |  |  |   |
| b. Due to (or as a consequence of):<br><b>Alzheimer's disease</b>  |  |  |   |
| c. Due to (or as a consequence of):  |  |  |   |
| d. Due to (or as a consequence of):  |  |  |   |
| Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>1 year</b>  |  |  |   |
| 23b. If female:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)       |   |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  |
|  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one) <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D26516</b>   | 29d. Date signed (Month, Day, Year)<br><b>APR 26 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALLEN J GILSON MD</b> <b>1475 TANEY AVE</b> <b>FRED MD 21702</b>  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br>  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15124

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Aubrey Alton Goode</b>   |  |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 22, 2012</b>      | 3. Time of Death<br>12:20 AM                                       |
| 4a. Facility Name (if not institution, give street and number)<br><b>Charlotte Hall Veterans Home</b>                                       |  |   |  | 4b. City, Town, or Location of Death<br><b>Charlotte Hall</b>  |  |   | 4c. County of Death<br><b>St. Mary's</b>                         |  |
| 5. Social Security Number<br><b>229-07-0172</b>   |  | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>103</b><br>Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>07/18/1908</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |  |
| Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Montgomery</b> 10c. City, Town or Location<br><b>Silver Spring</b> |  |   |  |  |  |   |  |  |
| 10e. Street and Number<br><b>10707 Blossom Lane</b>   |  |   |  | 10f. Zip Code<br><b>20903</b>  |  |   | 10g. Citizen of What Country?<br><b>United States</b>            |  |
| 11. Marital Status<br>1 □ Never Married 2 <b>X</b> Married<br>3 □ Widowed 4 □ Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <b>X</b> Yes 2 □ No <b>World War II</b><br>If Yes, Give Year or Dates. |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 <b>X</b> No <b>Specify:</b> |   |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>     |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>                                 |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>                 |  |   | 16b. Kind of Business Industry<br><b>Engineering</b>             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Raymond Goode</b>  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lilly Mae Walters</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn J. Hunt / Stepdaughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10707 Blossom Lane Silver Spring, MD 20903</b> |  |   |  |  |
| 20a. Method of Disposition<br>1 <b>X</b> Burial 2 □ Cremation 3 <b>X</b> Removal from State<br>4 □ Donation 5 □ Other (Specify)             |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Hope Cemetery</b>   |  |   | Date<br><b>04/27/2012</b>  | 20c. Location - City or Town, State<br><b>Marie, West Virginia</b> |
| 21. Signature of Funeral Service Licensee<br><b>► Willacy R. Bixby</b>  |  |   |  | 22. Name and Address of Facility Joseph Gawler's Sons Inc.<br><b>5130 Wisconsin Ave. NW Washington, DC 20016</b>                                   |  |   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |                          |  |  |  |
|---|--|---|--------------------------|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Donen Litz</b>   |  |   |                          |  | Approximate Interval Between Onset and Death                                 |  |
| <b>{</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>   |  |   |                          |  |  |  |
|   |  |   |                          |  |  |  |
|   |  |   |                          |  |  |  |
|   |  |   |                          |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 <b>X</b> No<br>9 □ Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |                          |  | 23d. Date of delivery<br>Month Day Year                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Heart Fibrosis</b><br><b>Coronary artery Disease</b><br><b>Deep venous thrombosis Right lower leg</b>  |  |   |                          |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 □ No 3 <b>X</b> Probably 4 □ Unknown |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 <b>X</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DDA<br>Other: 4 <b>X</b> Nursing Home 5 □ Residence 6 □ Other (Specify)  |                          |  | 24a. Was an autopsy performed?<br>1 □ Yes 2 <b>X</b> No                      |  |
| 27. Manner of Death<br>1 <b>X</b> Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 □ Yes 2 □ No | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier<br>1 <b>X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>Only one of the above may be checked. |  | 29c. License number<br><b>60037228MD</b>  |                          |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>                 |  |
| 29b. Signature and title of certifier<br><b>► Stephen Cafferty</b>  |  |   |                          |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen Cafferty MD 100 Hospital Road Prince Frederick, MD 20678</b>   |  |   |                          |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne P. Hart</b>  |                          |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15125

Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|   |  |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month <u>4</u> Day <u>21</u> Year <u>2012</u>  |  |  |   | 3. Time of Death<br><u>315 P M</u>   |  |
| Diane Esther Green  |  |  |  |  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death<br><u>Annapolis</u>   |  |  |   | 4c. County of Death<br><u>Anne Arundel</u>   |  |
| 748 Ballast Way   |  |  |  |  |   |  |  |
| 5. Social Security Number<br><u>364-34-5585</u>   |  | 6. Sex<br><u>1</u> <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>76</u> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days                                    | 8. Date of Birth<br>(Month, Day, Year)<br><u>1/15/1936</u>   | 9. Birthplace (State or Foreign Country)<br><u>MI</u>    |
| Usual Residence of Decedent<br>10a. State<br><u>MD</u>  |  | 10b. County<br><u>Anne Arundel</u>   |  | 10c. City, Town or Location<br><u>Annapolis</u>  |   |  |  |
| 10d. Inside City Limits<br><u>1</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |  |
| 10e. Street and Number<br><u>748 Ballast Way</u>  |  | 10f. Zip Code<br><u>21401</u>  |  |  |   | 10g. Citizen of What Country?<br><u>USA</u>  |  |
| 11. Marital Status<br><u>1</u> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><u>3</u> <input type="checkbox"/> Widowed <u>4</u> <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><u>5</u>  |  | 16b. Kind of Business/Industry<br><u>Writer/Editor</u><br><u>Government</u>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Max Yourofsky</u>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Tillie Shapiro</u>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Jerome Green</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>Spouse</u> <u>748 Ballast Way</u> <u>Annapolis, MD 21401</u>   |  |  |   |  |  |
| 20a. Method of Disposition<br><u>1</u> <input checked="" type="checkbox"/> Burial <u>2</u> <input type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State<br><u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Hillcrest Cemetery</u>  |  | Date<br><u>4/25/2012</u>   | 20c. Location - City or Town, State<br><u>Annapolis, MD</u> |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Jeri J. Green</u>   |  | 22. Name and Address of Facility<br><u>Hardesty Funeral Home, P.A.</u>   |  | 12 Ridgely Ave. Annapolis, MD 21401  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><u>KIDNEY CANCER</u>  |  |  |   | Approximate Interval Between Onset and Death<br><u>6 MONTHS</u>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. Due to (or as a consequence of):  |  |  |   |  |  |
| 23d. Date of delivery<br>Month <u>Day</u> <u>Year</u>   |  |  |  |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No<br><u>9</u> <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><u>1</u> <input type="checkbox"/> Live Birth <u>2</u> <input type="checkbox"/> Fetal death <u>3</u> <input type="checkbox"/> Ectopic pregnancy<br><u>4</u> <input type="checkbox"/> Pregnant at time of death <u>5</u> <input type="checkbox"/> Other (Specify)<br><u>9</u> <input type="checkbox"/> Unknown    |  |  |   | 23d. Date of delivery<br>Month <u>Day</u> <u>Year</u>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No <u>3</u> <input type="checkbox"/> Probably <u>4</u> <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> <input type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA<br>Other: <u>4</u> <input type="checkbox"/> Nursing Home <u>5</u> <input checked="" type="checkbox"/> Residence <u>6</u> <input type="checkbox"/> Other (Specify) |  |  |   | 23f. Was an autopsy performed?<br><u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No  |  |
| 27. Manner of Death<br><u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending Investigation<br><u>2</u> <input type="checkbox"/> Accident <u>6</u> <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><u>1</u> <input type="checkbox"/> Yes <u>2</u> <input type="checkbox"/> No   | 28d. Describe how injury occurred                           |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier<br>(Check only one)<br><u>1</u> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><u>3</u> <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   | 29b. Signature and title of certifier<br><u>Peter R. Green MD</u>  |  |
|   |  |  |  |  |   | 29c. License number<br><u>016364</u>   | 29d. Date signed (Month, Day, Year)<br><u>04/23/2012</u> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Peter R. Green MD 2003 MEDICAL PKWY 210 ANNAPOLIS MD 21401</u>   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 26 2012</u>   |  | 32. Registrar's Signature<br><u>Renae A. Parker</u>  |  |  |   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

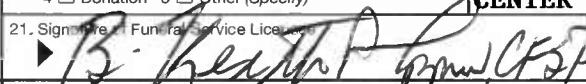
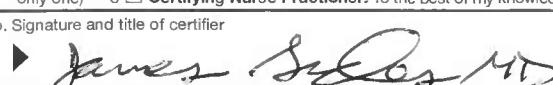
Amended #20c

TCHD, 4/24/2012, TLS

Certificate of Death

Reg. No.

2012 15126

|  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>MELVA G. HUBER</b>  |  |   |  |   | 2. Date of Death<br>Month <b>04</b> Day <b>20</b> Year <b>2012</b>               | 3. Time of Death<br><b>12:40 PM</b>  |  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>CAROLINE NURSING HOME</b>   |  |   | 4b. City, Town, or Location of Death<br><b>DENTON</b>  |   | 4c. County of Death<br><b>CAROLINE</b>   |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-03-6447</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/22/1920</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |  |
|  | Usual Residence of Decedent  |  | 10a. State <b>MD</b> 10b. County <b>CAROLINE</b> 10c. City, Town or Location <b>DENTON</b>  |  |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>520 KERR AVENUE</b>   |  |   | 10f. Zip Code<br><b>21629</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>-0-</b>  |  | 16b. Kind of Business Industry<br><b>HOMEMAKER</b>  |  | RESIDENCE  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN V. ADAMS</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LAURA HARVEY</b>         |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS GELDMACHER/DAUGHTER</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22098 BEAVEN DRIVE DENTON, MD 21629</b>          |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER</b>   |   |  | Date<br><b>04/21/2012</b>  | Location City, Town, State<br><b>STEVENSVILLE, MD</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   | 21b. Address of Funeral Service Licensee<br><b>FELLOWS HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A.<br/>200 SOUTH HARRISON STREET EASTON, MD 20601</b> |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Dementia</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>years</b>   |  |   |  |   |  |  |  |  |  |
|  | b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____   |  |   |  |   |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure<br/>Coronary Artery Disease</b>   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                             |  | 23f. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D31376</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>4-20-12</b>                            |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Sides MD</b>  |  |   |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>APR 24 2012</b>  |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15127

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   |  |  | 3. Time of Death   |  |
| PHYLLIS STINE HILL   |  | APRIL 24, 2012  |   |  |  | 08:30 A M  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   |  |  | 4c. County of Death  |  |
| FREDERICK MEMORIAL HOSPITAL  |  | FREDERICK   |   |  |  | FREDERICK  |  |
| 5. Social Security Number<br>217-28-5600   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>April 19, 1932   | 9. Birthplace (State or Foreign Country)<br>Maryland             |
| Usual Residence of Decedent<br>Maryland  |  | 10c. City, Town or Location<br>Thurmont   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |   | 10f. Zip Code<br>21788   |  |  | 10g. Citizen of What Country?<br>United States                   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Animal Caregiver  |   | 16b. Kind of Business/Industry<br>Animal Rescue  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Arthur Stine  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mildred Free  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Jane Nicholson / Daughter  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13259 Catoctin Furnace Rd., Thurmont, MD 21788   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens  |   | Date<br>April 26, 2012   |  | 20c. Location - City or Town, State<br>Frederick, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br>►   |  | 22. Name and Address of Facility<br>Resthaven Funeral Services, Skkot Cody P.A.<br>9501 Catoctin Mountain Hwy. Frederick, MD 21701  |   |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br>DAYS  |   |  |  |  |  |
| a. <i>Pneumonia</i><br>Due to (or as a consequence of):  |  |   |   |  |  |  |  |
| b. _____<br>Due to (or as a consequence of):   |  |   |   |  |  |  |  |
| c. _____<br>Due to (or as a consequence of):   |  |   |   |  |  |  |  |
| d. _____   |  |   |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>►   |  | 29c. License number<br><i>DOC 62223</i>   |   |  |  | 29d. Date signed (Month, Day, Year)<br><i>4/24/2012</i>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>PRAGEEEN B. STINE, 196 TJPNE, FREDERICK, MD 21702</i>   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 26 2012</i>  |  | 32. Registrar's Signature<br><i>Pragreen B. Stine</i>   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3  
Medical Certificate: To Be Completed by Physician/Medical Examiner  
State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

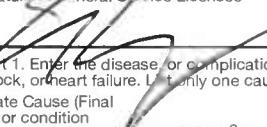
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15128

1 - For  
State  
Registrar

|                                     |   |  |   |   |   |   |   |  |  |
|-------------------------------------|---|--|---|---|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Howard Eugene Holland</b>  |  |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>20</b> Year <b>2012</b> | 3. Time of Death<br><b>7:20 PM</b>                                      |  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |   | 4c. County of Death<br><b>Frederick</b>                               |   |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>220-54-4331</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>62</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 11, 1949</b>         | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |
|                                     | Usual Residence of Decedent<br><b>Maryland</b>  |  | 10a. State<br><b>Frederick</b>  |   | 10c. City, Town or Location<br><b>Frederick</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br><b>6970 Rooks Court, Apt. 104</b>   |  |   | 10f. Zip Code<br><b>21703</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>                 |   |  |  |
|                                     | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printing Press Operator</b> |   |   | 16b. Kind of Business/Industry<br><b>Non-Profit</b>                     |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Donald John Holland</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Ellen Gilbert</b>   |   |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Diane King / Sister</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>612 East E Street, Brunswick, MD 21716</b>  |   |   |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of Cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens</b>                                 |   | Date<br><b>April 27, 2012</b>   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>       |  |  |
|                                     | 21. Signature - Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Resthaven Funeral Services, Skot Cody P.A.<br/>9501 Catoctin Mountain Hwy. Frederick, MD 21701</b>   |   |   |  |  |
|                                     | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial Infarction</b><br>Approximate Interval Between Onset and Death<br><b>minutes</b>   |  |   |   |   |   |   |  |  |
|                                     | b. Due to (or as a consequence of):<br><b>Hypertension</b><br>years   |  |   |   |   |   |   |  |  |
|                                     | c. Due to (or as a consequence of):   |  |   |   |   |   |   |  |  |
|                                     | d. _____  |  |   |   |   |   |   |  |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   |   | 23d. Date of delivery<br>Month Day Year                                 |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                     |   |  |   |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred                                     |   |  |  |
|                                     |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>DY3091</b>  | 29d. Date signed (Month, Day, Year)<br><b>4-23-12</b>                 |   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sami Zaidi, MD 801 Toll House Ave, Frederick, MD 21701</b>   |  |   |   |   |   |   |  |  |
| State Registrar                     | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |  | 32. Registrar's Signature<br>  |   |   |   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15129

3. Time of Death

2136 PM

|   |  |  |   |  |   |  |                                    |  |   |  |  |
|---|--|--|---|--|---|--|------------------------------------|--|---|--|--|
| 1 - For State Registrar   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Vernetta Rebecca Harmon</b>   |   |  |   | 2. Date of Death<br>Month <b>4</b> Day <b>23</b> Year <b>12</b>  | 3. Time of Death<br><b>2136 PM</b> |  |   |  |  |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>Peninsula Regional Medical Ctr</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Salisbury</b>   |                                    | 4c. County of Death<br><b>Wicomico</b>                         |   |  |  |
| Funeral<br>Director   |  | 5. Social Security Number<br><b>225-04-2866</b>  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (in yrs. last birthday)<br><b>37 Yrs.</b>   | If Under 1 Year<br>Months<br><b>0</b>   | If Under 24 Hrs<br>Hours<br><b>0</b>   | Min.<br><b>0</b>                   | 8. Date of Birth<br>(Month, Day, Year)<br><b>07/22/1974</b>    | 9. Birthplace (State or Foreign Country)<br><b>VA</b> |  |  |
| To Be Completed by Funeral Director   |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |   |  |   | 10b. County<br><b>Wicomico</b>   |                                    |  | 10c. City, Town or Location<br><b>Fruitland</b>       | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |
|   |  | 10e. Street and Number<br><b>216 N. Delany St.,</b>  |   |  |   | 10f. Zip Code<br><b>21826</b>  |                                    |  | 10g. Citizen of What Country?<br><b>USA</b>           |  |  |
| 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  |                                    | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> |   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>10</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>   |   |  | 16b. Kind of Business Industry<br><b>Disabled</b>   |  |                                    | N/A  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Steve Lee Harmon</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Diane Baines</b>   |   |  |   |  |                                    |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Steve L. Harmon / Father</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 157, Exmore, VA 23350</b>   |   |  |   |  |                                    |  |   |  |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Snead Memorial Cemetery</b>   |   |  | Date<br><b>4/28/2012</b>  | 20c. Location - City or Town, State<br><b>Keller, VA</b>   |                                    |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Shanae N. Cooper</b>  |  | 22. Name and Address of Facility<br><b>Cooper &amp; Humbles Funeral Co., Inc., Accomac, VA 23301</b>   |   |  |   |  |                                    |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death   |   |  |   |  |                                    |  |   |  |  |
| a. Due to (or as a consequence of):<br><b>ASCVD</b>   |  |  |   |  |   |  |                                    |  |   |  |  |
| b. Due to (or as a consequence of):   |  |  |   |  |   |  |                                    |  |   |  |  |
| c. Due to (or as a consequence of):   |  |  |   |  |   |  |                                    |  |   |  |  |
| d. Due to (or as a consequence of):   |  |  |   |  |   |  |                                    |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b> |   |  | 23d. Date of delivery<br>Month<br><b>0</b> Day<br><b>0</b> Year<br><b>0</b>   |  |                                    |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Diabetes mellitus</b><br><b>End-stage renal disease</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>  |   |  |   |  |                                    |  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | Hospital:<br><b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>  |   | 26. Place of Death (Check only one)<br><b>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                                    |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>  |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                      |                                    | 28d. Describe how injury occurred                              |   |  |  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |                                    |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29b. Signature and title of certifier<br><b>J. Mark</b>   |  | 29c. License number<br><b>DOO70129</b>   |   |  |   |  |                                    | 29d. Date signed (Month, Day, Year)<br><b>04-25-2012</b>       |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>IRFAN MCINNIS</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 27 2012</b>  |   |  |   |  |                                    |  |   | 32. Registrar's Signature<br><b>A. Parker</b>  |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15130

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>George H. Hill</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>20</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>3:05 A M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>South River Health &amp; Rehab</b>  |  | 4b. City, Town, or Location of Death<br><b>Edgewater</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |
| 5. Social Security Number<br><b>212-36-6071</b>  |  | 6. Sex<br><b>M</b>   | 7. Age (in yrs. last birthday)<br><b>74 Yrs.</b> | If Under 1 Year<br>Months      If Under 24 Hrs.<br>Days      Hours      Min.   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb 2 1938</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10. Inside City Limits<br><b>1 Yes 2 No</b>  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |  |
| 10e. Street and Number<br><b>223 Bowie Ave</b>   |  | 10f. Zip Code<br><b>21401</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>Specify: <b>Black</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>6th</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>O</b>  |  | 16b. Kind of Business/Industry<br><b>Groundskeeper</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>John H. Hill Sr</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys William</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John H. Hill Jr (Brother)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>223 Bowie Ave Annapolis, Md. 21401</b>   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Larry G. Reese</b>   |  | 20b. Place of Disposition (of cemetery, crematory or other place)<br><b>Hill Crest<br/>Memorial Gardens</b>  |  | Date<br><b>4-25-12</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Larry G. Reese</b>   |  | 20c. Location - City or Town, State<br><b>Wm. Reese &amp; Sons Mortuary, P.A.<br/>1922 Forest Dr. Annapolis, Md. 21401</b>   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>Atherosclerotic Cardiovascular disease</b>  |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |
| a. Due to (or as a consequence of):<br><b>Atherosclerotic Cardiovascular disease</b>   |  |  |  |  |
| b. Due to (or as a consequence of):  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month      Day      Year  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                     |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ayon C. Surana</b>   |  |  |
|  |  | 29c. License number<br><b>D. 50653</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-24-2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5851 Deale Churchton Road Deale MD 20751</b>  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br><b>Ayon C. Surana</b>   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15131

1-For State  
Registrar

Brian Michael Hendricks

Physician/  
Medical Examiner

|  |  |  |  |                                    |                              |
|--|--|--|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) |  |  |  | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>2130 hrs |
| Brian Michael Hendricks                  |  |  |  | April 22, 2012                     |                              |

|  |  |  |                                      |  |  |                     |
|--|--|--|--------------------------------------|--|--|---------------------|
| 4a. Facility Name (if not institution, give street and number) |  |  | 4b. City, Town, or Location of Death |  |  | 4c. County of Death |
| Anne Arundel Medical Center                                    |  |  | Annapolis                            |  |  | Anne Arundel        |

Funeral  
Director

|                           |  |                                |                           |                          |                               |  |
|---------------------------|--|--------------------------------|---------------------------|--------------------------|-------------------------------|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign Country) |
| 219-31-2795               | <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 21 Yrs.                        |                           |                          | March 4, 1991                 | Maryland                                 |

Usual Residence of Decedent

|            |              |                             |  |
|------------|--------------|-----------------------------|--|
| 10a. State | 10b. County  | 10c. City, Town or Location | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Maryland   | Anne Arundel | Annapolis                   |  |

|                        |               |                               |
|------------------------|---------------|-------------------------------|
| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| 619 Burley Rd.         | 21409         | USA                           |

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White | 14. Race - American Indian, Black, White, etc. |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced<br>If Yes, Give Year or Dates:    |  |  |  |

|  |  |                                |
|--|--|--------------------------------|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) | 16b. Kind of Business/Industry |
|  | 1 Electrical Apprentice  | Construction                   |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| Scott Emery Hendricks                   | Jeannine Marie Collinson                          |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Jeannine M. Hendricks-Mother                     | 619 Burley Rd., Annapolis, MD 21409   |

|  |  |           |                                     |
|--|--|-----------|-------------------------------------|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date      | 20c. Location - City or Town, State |
|  | Kalas Crematory  | 4/27/2012 | Edgewater, MD                       |

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br><i>Jeanne P. Kalas</i> | 22. Name and Address of Facility  |
|   | George P. Kalas Funeral Home, P.A.<br>2973 Solomons Island Rd., Edgewater, MD 21037 |

Baltimore, MD 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If Item 27 is marked either than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

|   |  |
|---|--|
| Immediate Cause (Final disease or condition resulting in death) | a. Multiple Blunt Force Injuries<br>Due to (or as a consequence of): |
|---|--|

|  |                                     |
|--|-------------------------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |
|--|-------------------------------------|

|                                     |                                     |
|-------------------------------------|-------------------------------------|
| c. Due to (or as a consequence of): | d. Due to (or as a consequence of): |
|-------------------------------------|-------------------------------------|

|  |  |
|--|--|
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |
|--|--|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|

|  |  |                                 |   |  |
|--|--|---------------------------------|---|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>Apr 22, 2012 | 28b. Time of Injury<br>2115 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Driver auto SUV collision |
|--|--|---------------------------------|---|--|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Major Road / Highway | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Harry S. Truman Parkway, Annapolis, MD |
|--|--|

|  |   |                                 |   |
|--|---|---------------------------------|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>one<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Russell Alexander MD.</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>April 23, 2012 |
|--|---|---------------------------------|---|

|   |  |   |      |
|---|--|---|------|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | 31. Date filed (Month, Day, Year)<br>APR 26 2012 | 32. Registrar's Signature<br><i>Laura A. Parker</i> | OCME |
|---|--|---|------|

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15132

**1-For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Sharon Marie Hensley

2. Date of Death  
Month Day Year  
April 28, 2012  
3. Time of Death  
2326 hrs**Funeral Director**

4a. Facility Name (if not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

572-63-0808

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

02/22/1978

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

106 Decker Street

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No3  Widowed4  Divorced

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Her Own Home

17. Father's Name (First, Middle, Last)

Conrad Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Wanda Faye Sellers

19a. Informant's Name/Relationship (Type, Print)

Kenneth Hensley, Jr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Decker Street, Elkton, MD 21921

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gilmor Manor Memorial Park

Date

May 7, 2012

20c. Location - City or Town, State

Elkton, MD

21. Signature of Funeral Service Licensee

*Conrad S. Hensley*

22. Name and Address of Facility

103 W. Stockton Street, Elkton, MD 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **Methadone and Morphine Intoxication**

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED 23a, 27, 28a-f, per me, g927 5-14-12 sm

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other:

27. Manner of Death

1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide7  Homicide

28a. Date of Injury (Month, Day, Year)

fd 4-28-12

28b. Time of Injury

fd 01:00 pm

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

106 Decker St.

Elkton, MD.

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Ana Rubio*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 29, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature

*Leanne J. Parker*

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2125133

|   |  |   |  |                              |  |  |                           |   |   |   |  |   |
|---|--|---|--|------------------------------|--|--|---------------------------|---|---|---|--|---|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Lorena Fallin Johnson</b>  |  |                              |  |  |                           | 2. Date of Death<br>Month<br><b>April</b>   | Day<br><b>28</b>  | Year<br><b>2012</b>   | 3. Time of Death<br><b>17:15 P M</b>                             |   |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>Hospice House of St. Mary's</b>  |  |                              |  |  |                           | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  |   | 4c. County of Death<br><b>St. Mary's</b>  |  |   |
| Funeral<br>Director                           |  | 5. Social Security Number<br><b>007-01-7015</b>   |  | 6. Sex<br><b>1 □ M 2 X F</b> | 7. Age (In yrs. last birthday)<br><b>94 Yrs.</b> |  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>06/30/1917</b> | 9. Birthplace (State or Foreign Country)<br><b>Biddeford, ME</b>  |  |   |
|   |  | Usual Residence of Decedent<br><b>MD</b>  |  | 10a. State<br><b>MD</b>      |  | 10b. County<br><b>St. Mary's</b>   |                           | 10c. City, Town or Location<br><b>Mechanicsville</b>  |   | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>  |  |   |
| To Be Completed by Funeral Director           |  | 10e. Street and Number<br><b>39498 Thomas Drive</b>   |  |                              |  |  |                           | 10f. Zip Code<br><b>20659</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |
|   |  | 11. Marital Status<br><b>1 □ Never Married 2 □ Married<br/>3 X Widowed 4 □ Divorced</b>   |  |                              |  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No<br/>If Yes, Give Year or Dates.</b>    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |
| To Be Completed by Funeral Director           |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>   |  |                              |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Homemaker</b> |                           |   |   | 16b. Kind of Business/Industry<br><b>Home</b>   |  |   |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Henry Xavier Girard</b>   |  |                              |  |  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louisa Mae Fillmore</b>                         |   |   |  |   |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ellen F. Harman / Daughter</b>   |  |                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>39498 Thomas Drive, Mechanicsville, MD 20659</b> |                           |   |   | 20c. Location - City or Town, State<br><b>Brinsfield-Echols Crem 04/30/2012 Charlotte Hall, MD</b>  |  |   |
|   |  | 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |  |                              |  |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols Crem</b> |   | Date<br><b>04/30/2012</b>   | 20c. Location - City or Town, State<br><b>Charlotte Hall, MD</b> |   |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b>Jennifer C. Schmidt #M00817</b>   |  |                              |  | 22. Name and Address of Facility<br><b>Brinsfield-Echols F.H., P.A.<br/>30195 Three Notch Rd., Charlotte Hall, MD 20622</b>                          |                           |   |   |   |  |   |
|   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Aspiration pneumonia</b>   |  |                              |  |  |                           | Approximate Interval Between Onset and Death  |   |   |  |   |
| To Be Completed by Physician/Medical Examiner |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 X No<br/>9 □ Unknown</b>  |  |                              |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death<br/>4 □ Pregnant at time of death<br/>9 □ Unknown</b>                         |                           |   |   | 23d. Date of delivery<br>Month Day Year   |  |   |
|   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>  |  |                              |  |  |                           | 23f. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>    |   |   |  |   |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |  |                              |  | 26. Place of Death (Check only one)<br>Hospital:<br><b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b>   |                           |   |   | 26. Place of Death (Check only one)<br>Other:<br><b>4 □ Nursing Home 5 □ Residence 6 X Other (Specify)</b><br><b>Hospice House</b>            |  |   |
|   |  | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide<br/>4 □ Homicide</b>   |  |                              |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>28b. Time of injury<br/>M</b>  |                           | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>   |   | 28d. Describe how injury occurred   |  |   |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  |                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>At home</b>   |                           |   |   |   |  |   |
|   |  | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated<br/>only one<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |                              |  | 29b. Signature and title of certifier<br><b>J. Schmidt</b>   |                           |   |   | 29c. License number<br><b>M0055751</b>  |  |   |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer M. Schmidt, 40900 Merchants Ln., St #205, Leonardtown, MD 20650</b>   |  |                              |  |  |                           | 29d. Date signed (Month, Day, Year)<br><b>04-28-12</b>  |   |   |  |   |
|   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 02 2012</b>   |  |                              |  |  |                           | 32. Registrar's Signature<br><b>Jennifer M. Schmidt</b>   |   |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

5+  
some  
P

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15134

1-  
For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |  |  |  |  |   |  |   |  |
|-------------------------------------|--|--|--|--|--|---|--|---|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>Beatrice Jones</b>  |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>20</b> Year <b>2012</b>   |  | 3. Time of Death<br>1005 M  |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>220-16-7349</b>  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 18 1925</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |  |   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |
|                                     |  | 10e. Street and Number<br><b>110 Southvilla Ave</b>  |  |  |  | 10f. Zip Code<br><b>21401</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|                                     |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>                                   |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 2yrs Nurse</b>        | 16b. Kind of Business/Industry<br><b>Anne Arundel General Hospital</b>   |  |   |  |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Robert Randall</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice V. Lane</b>  |  |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gail P. Jones (Daughter)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>110 Southvilla Ave Annapolis, Md. 21401</b> |  |   |  |
|                                     |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veteran</b>  |  | Date<br><b>5-1-12</b>   | 20c. Location - City or Town, State<br><b>Crownsville, Md.</b> |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Larry H. Reese</b>   |  |  |  | Name and address of facility<br><b>H. H. Reese &amp; Sons Mortuary, P.A.<br/>1922 Forest Dr. Annapolis, Md. 21401</b>                           |  |   |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Aortic Stenosis</b>   |  |  |  |   |  |   |  |
|                                     |  | Approximate Interval Between Onset and Death   |  |  |  |   |  |   |  |
|                                     |  | Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |   |  |   |  |
|                                     |  | 23b. If Yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |
|                                     |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Colon Cancer</b>  |  |  |  |   |  |   |  |
|                                     |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |   |  |   |  |
|                                     |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |
|                                     |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  |   |  |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |
|                                     |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |   |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |  |  |   |  |   |  |
|                                     |  | 28a. Date of Injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |   |  |
|                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |   |  |
|                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
|                                     |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
|                                     |  | 29b. Signature and title of certifier<br><b>Sjouvel Bush, MD</b>   |  |  |  |   |  |   |  |
|                                     |  | 29c. License number<br><b>D46052</b>   |  |  |  |   |  |   |  |
|                                     |  | 29d. Date signed (Month, Day, Year)<br><b>4/20/12</b>  |  |  |  |   |  |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sjouvel Bush, MD 2000 Medical Parkway, Annapolis</b>  |  |  |  |   |  |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  |  |  |   |  |   |  |
|                                     |  | 32. Registrar's Signature<br><b>Anna S. Parker</b>   |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15135

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ELLEN K JOHNSON</b>   |  | 2. Date of Death<br>Month <b>04</b> Day <b>23</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>2212 M</b>                            |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>         |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                   |  |
| 5. Social Security Number<br><b>218-12-9402</b>  |  | 6. Sex<br><b>M</b>   | 7. Age (In yrs. last birthday)<br><b>92 Yrs.</b>   | If Under 1 Year<br>Months                                    | If Under 24 Hrs.<br>Hours                                      |
| Usual Residence of Decedent<br><b>Maryland Anne Arundel</b>  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov 19 1919</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |  | 10d. Inside City Limits<br><b>Yes</b>                          |
| 10e. Street and Number<br><b>779 Annapolis Neck Rd.</b>  |  | 10f. Zip Code<br><b>21403</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                  |  |
| 11. Marital Status<br><b>Widowed</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>Yes</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>No</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6th</b> |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                |  | 16b. Kind of Business/Industry<br><b>Private Family</b>      |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles E. Kirby</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadie A. Davis</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Benjamin D. Kirby (Son)</b>                           |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>104 Rosecrest Dr. Annapolis, Md. 21403</b> |  |  |  |
| 20a. Method of Disposition<br><b>Burial</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Memorial Gardens</b>  | Date<br><b>4-28-12</b>   | 20c. Location - City or Town, State<br><b>Annapolis, Md.</b> |  |
| 21. Signature of Funeral Service Licensee<br><b>Larry S. Reese</b>   |  | Name and address of facility<br><b>Wm. Reese &amp; Sons Mortuary, P.A.<br/>1922 Forest Dr. Annapolis, Md. 21401</b>                            |  |  |  |

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

|  |  |   |                          |  |                                   |
|--|--|---|--------------------------|--|-----------------------------------|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br><b>Acute CONGESTIVE HEART FAILURE</b>  |  | Approximate Interval Between Onset and Death<br><b>Days</b>   |                          |  |                                   |
| b. Due to (or as a consequence of):<br><br><b>ACUTE MYOCARDIAL INFARCTION</b>  |  | Approximate Interval Between Onset and Death<br><b>Days</b>   |                          |  |                                   |
| c. Due to (or as a consequence of):<br><br><b>HYPERTENSION</b>   |  | Approximate Interval Between Onset and Death<br><b>Years</b>  |                          |  |                                   |
| d.   |  |   |                          |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>6 <input type="checkbox"/> Unknown |                          |  |                                   |
| 23d. Date of delivery<br>Month Day Year  |  |   |                          |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DIABETES</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                          |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                          |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D 21438</b>   |                          | 29d. Date signed (Month, Day, Year)<br><b>April 24 2012</b>                          |                                   |
| 29b. Signature and title of certifier<br><br><b>Michael J. Lafenta</b>   |  |   |                          |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><br><b>MICHAEL J. LAFENTA NO 445 DEFENSE Hwy ANNAPOULS MD 21401</b>  |  |   |                          |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br><br><b>Leanne S. French</b>  |                          |  |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15136

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |                              |
|--|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month April Day 26 Year 2012 | 3. Time of Death<br>6:20 P M |
|--|--|------------------------------|

Ellen Buskirk Keyes

|  |  |                                   |
|--|--|-----------------------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death<br>Gaithersburg | 4c. County of Death<br>Montgomery |
|--|--|-----------------------------------|

|  |  |   |                           |                                     |   |  |
|--|--|---|---------------------------|-------------------------------------|---|--|
| 5. Social Security Number<br>577-22-7671 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br>92 Yrs. | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>Jan. 14, 1920 | 9. Birthplace (State or Foreign Country)<br>Washington, DC |
|--|--|---|---------------------------|-------------------------------------|---|--|

|                  |                           |                                       |  |
|------------------|---------------------------|---------------------------------------|--|
| 10a. State<br>MD | 10b. County<br>Montgomery | 10c. City, Town or Location<br>Boyd's | 10d. Inside City Limits<br><input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|------------------|---------------------------|---------------------------------------|--|

|  |                        |   |
|--|------------------------|---|
| 10e. Street and Number<br>12204 Greenridge Drive | 10f. Zip Code<br>20841 | 10g. Citizen of What Country?<br>U.S.A. |
|--|------------------------|---|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>White | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|--|---|--|--|

|   |   |  |
|---|---|--|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>1<br>Secretary | 16b. Kind of Business Industry<br>Montgomery County Public Schools |
|---|---|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br>Harry McDowell | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jessie Foster |
|---|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Barbara B. Angelino/Daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12204 Greenridge Drive, Boyd's, MD 20841 |
|--|---|

|   |  |                    |   |
|---|--|--------------------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>Metropolitan Crem. | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crem. | Date<br>04/28/2012 | 20c. Location - City or Town, State<br>Alexandria, VA |
|---|--|--------------------|---|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br>► <i>Dawn McMillian</i> | 22. Name and Address of Facility<br>DeVol Funeral Home<br>MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 |
|--|--|

|  |  |
|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
|--|--|

|   |  |
|---|--|
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a consequence of): <i>Artherosclerotic cardiovascular disease</i> |
|   | b. Due to (or as a consequence of):  |
|   | c. Due to (or as a consequence of):  |
|   | d. Due to (or as a consequence of):  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|--|

|  |   |                          |  |                                   |
|--|---|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury<br>(Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|---|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |                                |  |
|--|--------------------------------|--|
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br>R139631 | 29d. Date signed (Month, Day, Year)<br>4/27/2012 |
|--|--------------------------------|--|

|  |
|--|
| 29b. Signature and title of certifier<br>► <i>Elizabeth Kim</i> Certified Nurse Practitioner |
|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Elizabeth Kim, CNRP, 301 Russell Avenue, Gaithersburg, MD 20877 |
|---|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>APR 30 2012 | 32. Registrar's Signature<br><i>Linda J. Patel</i> |
|--|--|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

12

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15137

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

State  
Registrar

Division of Vital Records, P.O. Box 68760

3

|  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Olga Kazakova</b>   |  |  |  |  |  | 2. Date of Death<br><b>April 24, 2012</b>   |  | 3. Time of Death<br><b>2014 M</b>  |  |  |   |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Adventist</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |  |  |  |   |  |
|  |  | 5. Social Security Number<br><b>220-53-0284</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b><br>Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>9/2/1935</b>  | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>   |  |  |  |  |   |  |
|  |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  |  | 10b. County<br><b>Montgomery</b>   |  |  | 10c. City, Town or Location<br><b>Rockville</b>   |  |  |  |  |   |  |
|  |  | 10e. Street and Number<br><b>806 New Mark Esplanade</b>  |  |  | 10f. Zip Code<br><b>20850</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |  |   |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |  |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Scientist</b>   |  |  | 16b. Kind of Business Industry<br><b>Russian Academy of Science</b>   |  |  |  |  |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Vladimir Kazakov</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irina Brezeska</b>   |  |   |  |  |  |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leonid Boudakov/Husband</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>806 New Mark Esplanade Rockville, Md 20850</b>   |  |  |   |  |  |  |  |   |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rock Creek Cem.</b>   |  |  | Date<br><b>4/27/2012</b>  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>             |  |  |  |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  |  |  | 21. Signature of Funeral Service Licensee<br><b>PHILIP D. RINALDI FUNERAL SERVICE, P.A.</b><br>9241 Columbia Blvd. Silver Spring, Md 20910   |  |  |   |  |  |  |  |   |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |  |   |  |
|  |  | 23d. Date of delivery<br>Month Day Year  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |  |  |   |  |
|  |  | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  | 23g. Did alcohol contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide |   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>April 26, 2012</b>   |  | 28b. Time of injury<br><b>0200 A M</b> | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>tripped and fell</b> |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>806 New Mark Esplanade, Rockville, Maryland</b>   |  |  |   |  |  |  |  |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0064413</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 26, 2012</b>   |   |  |  |  |  |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Juanita Smith MD 9901 Medical Center Drive, Parkville, Maryland 20850</b>   |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  |  | 32. Registrar's Signature<br><b>Susan P. Jacek</b>  |  |  |  |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

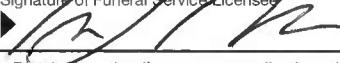
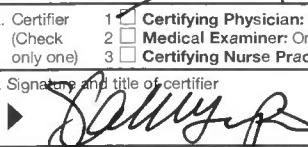
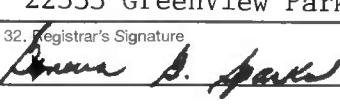
## Certificate of Death

2012 15138

Reg. No.

1 - For State Registrar

Physician/  
Medical  
Examiner

|   |  |   |  |
|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Winifred Ruth Kidd</b>   |  | 2. Date of Death<br>Month April Day 22, Year 2012   | 3. Time of Death<br>1:00 P M   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Charlotte Hall Veterans Home</b>   |  | 4b. City, Town, or Location of Death<br><b>Charlotte Hall</b>   | 4c. County of Death<br><b>St. Mary's</b>   |
| 5. Social Security Number<br><b>196-18-2522</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |
|   |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.  |
|   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 10, 1922</b>   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  | 10c. City, Town or Location<br><b>Edgewater</b>  |
| 10e. Street and Number<br><b>322 Arbutus Drive</b>  |  | 10f. Zip Code<br><b>21037</b>   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1944-46</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Guidance Office Secretary</b>  | 16b. Kind of Business Industry<br><b>Education</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Otto Walpuski</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Maust</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vicki A. Kohne / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>810 Harmony Way, Centreville, Maryland 21617</b>  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Epiphany Cemetery</b>  | 20c. Date<br><b>4-26-12</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility George P. Kalas Funeral Home<br><b>2973 Solomons Island Rd., Edgewater, MD 21037</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |  |
| a. <b>Cervical Disc Disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b><br><b>Hypertension</b><br><b>Hypo thyroidism</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   |
|   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>10037228 mro</b>  |  |
| 29b. Signature and title of certifier<br>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen Cafferty M.D.</b> 22333 Greenview Parkway, Unit 5A, Great Mills, MD 20634  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |  |
| 32. Registrar's Signature<br>  |  |   |  |

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

CASTI

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15139

1 - For  
State  
Registrar

|                                   |  |  |   |  |  |   |
|-----------------------------------|--|--|---|--|--|---|
| Physician/<br>Medical<br>Examiner | 1. Decedent's Name (First, Middle, Last)<br><i>Curtis Karner</i>                           |  |   |  | 2. Date of Death<br>Month <input checked="" type="checkbox"/> April Day <input checked="" type="checkbox"/> 24 Year <input checked="" type="checkbox"/> 2012 | 3. Time of Death<br><input checked="" type="checkbox"/> 7:07 p.m. |
|                                   | 4a. Facility Name (if not institution, give street and number)<br><i>Suburban Hospital</i> |  | 4b. City, Town, or Location of Death<br><i>Bethesda</i> |  | 4c. County of Death<br><i>Montgomery</i>   |   |
| Funeral<br>Director               | 5. Social Security Number<br><input checked="" type="checkbox"/> 195-30-8183               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>72 Yrs.               | If Under 1 Year<br>Months<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4<br><input type="checkbox"/> 5<br><input type="checkbox"/> 6<br><input type="checkbox"/> 7<br><input type="checkbox"/> 8<br><input type="checkbox"/> 9<br><input type="checkbox"/> 10<br><input type="checkbox"/> 11<br><input type="checkbox"/> 12<br><input type="checkbox"/> 13<br><input type="checkbox"/> 14<br><input type="checkbox"/> 15<br><input type="checkbox"/> 16<br><input type="checkbox"/> 17<br><input type="checkbox"/> 18<br><input type="checkbox"/> 19<br><input type="checkbox"/> 20<br><input type="checkbox"/> 21<br><input type="checkbox"/> 22<br><input type="checkbox"/> 23<br><input type="checkbox"/> 24<br><input type="checkbox"/> 25<br><input type="checkbox"/> 26<br><input type="checkbox"/> 27<br><input type="checkbox"/> 28<br><input type="checkbox"/> 29<br><input type="checkbox"/> 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15140

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

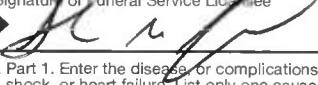
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |   |  |  |  |   |  |   |
|--|--|---|--|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month May Day 3 Year 2012   |  |  |  | 3. Time of Death<br>10:26 P M                                     |  |   |
| MARGARETE MCCLAIN KEMP   |  |   |  |  |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  |  |  | 4c. County of Death<br><b>Frederick</b>                           |  |   |
| 5. Social Security Number<br><b>215-50-1290</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 19, 1920</b>    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>7990 Serenity Court</b>   |  | 10f. Zip Code<br><b>21701</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>             |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>3</b>   |  | 16b. Kind of Business/Industry<br><b>Nurse</b>   |  |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Edward M. McClain</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Fink</b>   |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sherry Kemp / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7990 Serenity Court, Frederick, MD 21701</b>  |  |  |  |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |  | 20c. Date of Disposition<br><b>May 7, 2012</b>   |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b> |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Keeney and Basford PA Funeral Home<br/>106 East Church Street, Frederick, Maryland 21701</b>   |  |  |  |   |  |   |
| 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure; List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure; List only one cause in each line.<br>Coronary Artery Disease   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>8 yrs.</b> |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 23f. Did alcohol contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |   |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                                 |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  |  |  |   |  |   |
| 29c. License number<br><b>D-13971</b>  |  | 29d. Date signed (Month Day, Year)<br><b>5/4/12</b>   |  |  |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert L. Kaufman, M.D. 300 W. Ninth Street, Frederick, Maryland 21701</b>  |  |   |  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15141

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Richard  
Division of Vital Records, PO. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Richard Weymouth Loheed Sr.</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 28, 2012</b>   | 3. Time of Death<br>10:16 p.m.                                   |
| 4a. Facility Name (if not institution, give street and number)<br><b>St. Mary's Hospital</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  | 4c. County of Death<br><b>St. Mary's</b>                         |
| 5. Social Security Number<br><b>160-14-6836</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>97</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>03/04/1915</b>  | 9. Birthplace (State or Foreign Country)<br><b>Argentina</b>     |
| Usual Residence of Decedent<br>10a. State<br><b>Maryland</b>   |  |   |   | 10b. County<br><b>St. Mary's</b>  | 10c. City, Town or Location<br><b>Valley Lee</b>                 |
| 10e. Street and Number<br><b>18920 Piney Point Road</b>  |  |   |   | 10f. Zip Code<br><b>20692</b>   | 10g. Citizen of What Country?<br><b>United States</b>            |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Engineer</b>   |   | 16b. Kind of Business Industry<br><b>Engineering</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Irwin Loheed</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Gladys Jones</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard W. Loheed, Jr./Son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18920 Piney Point Road, Valley Lee, MD 20692</b>  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Kathleen Santivasci</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols Cre</b>  |   | Date<br><b>05/04/2012</b>   | 20c. Location - City or Town, State<br><b>Charlotte Hall, MD</b> |
| 21. Funeral Home/Funeral Service Licensee<br><b>Kathleen Santivasci M00872</b>   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>  |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |   | Approximate Interval Between Onset and Death<br><b>minutes</b>  |  |
| <p>a. <i>Cardiac arrhythmia</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Hypoxia</i><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown            |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                                |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>James Issam Damalsi</i>  |  | 29c. License number<br><b>D29821</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 28, 2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES ISSAM DAMALSI PO BOX 524 LEONARDTOWN, MD 20650</b>  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 2012</b>  |  | 32. Registrar's Signature<br><i>James S. Parker</i>   |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15142

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

TOB: 0500  
Baltimore, Maryland 21215-0036  
DOD: 4/25/12  
Known to Physician: Richard Loftus  
Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician/  
Medical  
Examiner

Medical Certificate To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  |   |  | 3. Time of Death<br>5:00 A M   |
| Richard S. Loftus  |  | April, 25, 2012   |  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |  |   | 4c. County of Death  |  |
| Homewood at Crumland Farms   |  | Frederick   |  |   | Frederick  |  |
| 5. Social Security Number  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br>86 Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br>May 19, 1925                           | 9. Birthplace (State or Foreign Country)<br>Michigan   |
| 363-26-5596  |  |   |  |   |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |
| 10a. State   | 10b. County  | 10c. City, Town or Location   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Maryland   | Frederick  | Frederick   |  |   |  |  |
| 10e. Street and Number<br>7407 Willow Rd.  |  |   | 10f. Zip Code<br>21702   |   |  | 10g. Citizen of What Country?<br>USA   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br>WWII  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)   |  | 5+  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Teacher  |   |  | 16b. Kind of Business Industry<br>Education  |
| 17. Father's Name (First, Middle, Last)<br>Leo Loftus  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Austin  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Barbara Loftus / Daughter In Law   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2504 Catoctin Court #3A, Frederick, MD 21702  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Stauffer Crematory  |  | Date<br>4/27/2012   | 20c. Location - City or Town, State<br>Frederick, Maryland                       |  |
| 21. Signature of Funeral Service Licensee<br>Courtney Stauffer   |  | 22. Name and Address of Facility<br>Stauffer Funeral Home<br>1621 Opossumtown Pike, Frederick, MD 21702   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |  |  |
| a. Due to (or as a consequence of):<br>PARKINSON'S DISEASE<br>Approximate Interval Between Onset and Death<br>10 yrs   |  |   |  |   |  |  |
| b. Due to (or as a consequence of):  |  |   |  |   |  |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION SPINAL STENOSIS<br>HYPERLIPIDEMIA   |  |   |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>A. J. Donelson MD   |  | 29c. License number<br>021986   |  |   | 29d. Date signed (Month, Day, Year)<br>4/28/2012                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>A. J. Donelson MD 650 Thomas Jefferson Dr, FREDERICK, MD 21702   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 26 2012   |  | 32. Registrar's Signature<br>Karen A. Park  |  |   |  |  |

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

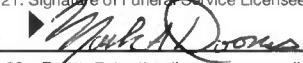
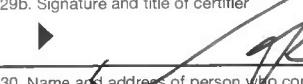
**Certificate of Death**

Reg. No.

2012 15143

**1-** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Wilton Paul Ledet</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 20, 2012</b>  |  | 3. Time of Death<br>10:32 P M  |
| 4a. Facility Name (if not institution, give street and number)<br><b>5918 Overlea Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>579-32-0280</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>If Under 24 Hrs<br>Hours Min.   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>09/09/1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Louisiana</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Bethesda</b>   |
| 10e. Street and Number<br><b>5918 Overlea Road</b>   |  | 10f. Zip Code<br><b>20816</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1944-1946</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Servant</b>   |  | 16b. Kind of Business/Industry<br><b>Defense Intelligence</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Kelles Ledet</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Auxilla Angeran</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Ledet / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5918 Overlea Road Bethesda, MD 20816</b>   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>National Crematory</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Crematory</b>  |  | Date<br><b>04/24/2012</b>  |
| 20c. Location - City or Town, State<br><b>Falls Church, VA</b>   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons Inc.</b><br><b>5130 Wisconsin Ave. NW Washington, DC 20016</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Approximate Interval Between Onset and Death Hours   |
| <p>a. <b>Terminal Cardiac Arrhythmia</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown           |
|  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Describe how injury occurred  |
|  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  |  |
|  |  | 29c. License number<br><b>D0065914</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Amy Schiffman MD 9613 Bellevue Drive Bethesda, MD 20814</b>   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br>   |  |  |

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

10

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15144

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death   |
| <b>Joel Perry Marquis</b>  |  | May 2 2012   |  | 4:55 a.m.  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death  |
| <b>Hospice House of St. Mary's</b>   |  | <b>Callaway</b>  |  | <b>St. Mary's</b>  |
| 5. Social Security Number<br><b>215-62-6702</b><br>Usual Residence of Decedent   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   | If Under 1 Year<br>Months Days Hours Min.<br>If Under 24 Hrs.  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>St. Mary's</b>   | 10c. City, Town or Location<br><b>Mechanicsville</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b> |
| 10e. Street and Number<br><b>27942 Cedar View Court</b>  |  | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesperson</b>   |  | 16b. Kind of Business/Industry<br><b>Automobile Sales</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Paul Marquis</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris Edwards</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia F. Marquis/ Spouse</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27942 Cedar View Ct. Mechanicsville, MD 20659</b>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brinsfield-Echols Cre.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols Cre.</b>  | Date<br><b>05/03/2012</b>  | 20c. Location - City or Town, State<br><b>Charlotte Hall, MD</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Margaret H. Hicks, MO1631</b>  |  | 22. Name and Address of Facility<br><b>22955 Hollywood Road Brinsfield Funeral Home, P.A. Leonardtown, MD 20650</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death   |  |  |
| a. <b>Liver Cancer</b><br>Due to (or as a consequence of):   |  |  |  |  |
| b. Due to (or as a consequence of):  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown                |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House</b> |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No              |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                             |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Jennifer Schmidt, M.D.</b>   |  |  |
|  |  | 29c. License number<br><b>MOU55751</b>   |  |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>5-2-2012</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Schmidt, M.D. 40900 Merchants Lane Suite 205 Leonardtown, MD 20650</b>   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 2012</b>  |  | 32. Registrar's Signature<br><b>Anne B. Farley</b>   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15145

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

|   |  |   |  |   |   |   |  |  |  |                                     |  |
|---|--|---|--|---|---|---|--|--|--|-------------------------------------|--|
|   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Norton Miles</b>  |  |   |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> , Year <b>2012</b>  |  | 3. Time of Death<br><b>11:20 AM</b> |  |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>827 Boatswain Way</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |                                     |  |
| Funeral<br>Director                           |  | 5. Social Security Number<br><b>213-42-7664</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>88 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 8, 1923</b> | 9. Birthplace (State or Foreign<br>Country)<br><b>Washington, DC</b>   |  |                                     |  |
| To Be Completed by Funeral Director           |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Annapolis</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                     |  |
|   |  | 10e. Street and Number<br><b>827 Boatswain Way</b>  |  |   | 10f. Zip Code<br><b>21401</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                     |  |
| Physician/<br>Medical<br>Examiner             |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |  | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: <b>White</b> |                                     |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator</b>   |   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |                                     |  |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Raymond Howard Norton</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Bell</b>   |   |  |  |  |                                     |  |
|   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mignon Percival /Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>874 Lenox Oaks Circle N.E., Atlanta, Georgia 30324</b>  |   |  |  |  |                                     |  |
|   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Darnestown Presby. Cemetery</b>  |   |  | Date<br><b>4-28-2012</b>   | 20c. Location - City or Town, State<br><b>Darnestown, Maryland</b>         |                                     |  |
|   |  | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Rd., Edgewater, MD 21037</b>   |   |  |  |  |                                     |  |
|   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  | Approximate Interval Between Onset and Death<br><b>6 weeks</b>   |  |                                     |  |
|   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown   |  |   | 23d. Date of delivery<br>Month Day Year   |   |  |  |  |                                     |  |
|   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>emphysema</b>  |   |  |  |  |                                     |  |
|   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |                                     |  |
|   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  |                                     |  |
|   |  | 28a. Date of injury (Month, Day, Year)  |  |   | 28b. Time of injury<br>M  |   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                     |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Describe how injury occurred   |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                     |  |
|   |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number<br><b>019838</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/2012</b>  |  |                                     |  |
|   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stuart E. Selonick, MD 2003 Medical Parkway, Annapolis, Md.</b>  |  |   | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |   |  | 32. Registrar's Signature<br>   |  |                                     |  |

Baltimore, Maryland 21215-0036

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Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15146

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|   |  |  |  |  |   |   |   |
|---|--|--|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month 4 Day 23 Year 2012   |  |  |   | 3. Time of Death<br>10:10 A.M.                              |   |
| <b>JOYCE M. MAXEY</b>   |  |  |  |  |   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>1706 Severn Chapel Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Millersville</b>  |  |  |   | 4c. County of Death<br><b>Anne Arundel</b>                  |   |
| 5. Social Security Number<br><b>225-34-7827</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                                     | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/25/1932</b> | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |
| Usual Residence of Decedent:<br><br>10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Millersville</b>   |   |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |
| 10e. Street and Number<br><b>1706 Severn Chapel Road</b>  |  |  |  | 10f. Zip Code<br><b>21108</b>  |   |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b><br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Lockett</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Grady</b>  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James D. Maxey Jr. Spouse</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1706 Severn Chapel Road Millersville, MD 21108</b>   |   |   |   |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans</b>   |  | Date   | 20c. Location - City or Town, State<br><b>Crownsville, MD</b> |   |   |
| 21. Signature of Funeral Service Licensee<br><b>Galt J. Orr</b>   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A. Gambrills, MD 21054</b>  |  |  |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |   |   |   |
| a. Due to (or as a consequence of):<br><br><b>END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |  |  |  |  |   |   |   |
| b. Due to (or as a consequence of):   |  |  |  |  |   |   |   |
| c. Due to (or as a consequence of):   |  |  |  |  |   |   |   |
| d. Due to (or as a consequence of):   |  |  |  |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b><br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month Day Year                     |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |  |  |  |  |   |   |   |
| 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |   |   |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>   |  | Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>   |   |   |   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b><br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide<br>6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>28b. Time of injury<br/>M</b>  |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   | 28d. Describe how injury occurred                           |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |   |
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D 21438</b>  |  |  |   |   |   |
| 29b. Signature and title of certifier<br><b>Michael J. LaPenta Jr.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 25 2012</b>  |  |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>445 Defense Hwy<br/>Annapolis, MD 21401</b>  |  |  |  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |  | 32. Registrar's Signature<br><b>Anna S. Parker</b>   |  |  |   |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15147

1 - For  
State  
Registrar

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Mary Nash</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 19, 2012</b>  | 3. Time of Death<br>4:00 A M                          |
| 4a. Facility Name (if not institution, give street and number)<br><b>Manor Care Bethesda</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |   |
| 5. Social Security Number<br><b>579-52-5439</b>   |  |   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>78 Yrs.</b>      |
|   |  |   |  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.                   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>July 1, 1933</b>   |  |   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |   |
| 10a. State<br><b>MD</b>   |  |   |  | 10b. County<br><b>Montgomery</b>   |   |
| 10c. City, Town or Location<br><b>Bethesda</b>  |  |   |  | 10d. Inside City Limits<br><b><input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |   |
| 10e. Street and Number<br><b>5621 Bent Branch Road</b>  |  |   |  | 10f. Zip Code<br><b>20816</b>  | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>                    |  | 16b. Kind of Business/Industry<br><b>Homemaker</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Richard M. Nash</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Baxter</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James W. Ketchum / Cousin</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5621 Bent Branch Road Bethesda, MD 20816</b>   |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b> |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Crematory</b>  | Date<br><b>4-30-2012</b>                              |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 20c. Location - City or Town, State<br><b>Falls Church, VA</b>   |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons Inc.<br/>5130 Wisconsin Ave. NW Washington, DC 20016</b>   |   |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |                          |   |  |
|--|--|--|--------------------------|---|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | <b>CORONARY ARTERY DISEASE</b>   |                          |   | Approximate Interval Between Onset and Death                                 |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):  |                          |   |  |
|  |  | b. Due to (or as a consequence of):  |                          |   |  |
|  |  | c. Due to (or as a consequence of):  |                          |   |  |
|  |  | d. Due to (or as a consequence of):  |                          |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br/>4 <input type="checkbox"/> Pregnant at time of death<br/>9 <input type="checkbox"/> Unknown</b> |                          |   | 23d. Date of delivery<br>Month Day Year                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                          | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>   |                          | Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>  |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. Signature and title of certifier<br>   |                          |   |  |
|  |  | 29c. License number<br><b>00057124</b>   |                          |   | 29d. Date signed (Month, Day, Year)<br><b>4/19/12</b>                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Truong Bao MD 10110 Molecular Drive Suite #206 Rockville, MD 20850</b>  |  |  |                          |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br>   |                          |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

15

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No

2012 15148

|   |  |   |  |  |  |  |                           |   |   |
|---|--|---|--|--|--|--|---------------------------|---|---|
| <b>Physician/<br/>Medical<br/>Examiner</b><br><br><b>Baltimore, Maryland 21215-0036</b><br><br><small>Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small>  |  | 1. Decedent's Name (First, Middle, Last)<br><b>CORDELIA NEARY</b>   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>98th</b> Year <b>2012</b>  |                           | 3. Time of Death<br><b>9:50A</b>  |   |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>HARBOR HOSPITAL</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                           | 4c. County of Death<br><b>None</b>  |   |
| <b>Funeral<br/>Director</b><br><br><b>To Be Completed by Funeral Director</b>   |  | 5. Social Security Number<br><b>216-20-0762</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours | 8. Date of Birth<br>(Month, Day, Year)<br><b>01/09/1927</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|   |  | Usual Residence of Decedent<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |                           | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |
|   |  | 10e. Street and Number<br><b>3240 Old Fence Court</b>   |  |  |  | 10f. Zip Code<br><b>21042</b>  |                           | 10g. Citizen of What Country?<br><b>United States</b>   |   |
|   |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b>White</b> |                           | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |   |
|   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>3</b><br><b>Homemaker</b>                                       |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |                           |   |   |
|   |  | 17. Father's Name (First, Middle, Last)<br><b>Karl Hellman</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Shellenberger</b>   |                           |   |   |
|   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Roy F. Neary, Jr. - Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3240 Old Fence Court Ellicott City, MD 21042</b>   |  | Date   |                           | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>  |   |
|   |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crest Lawn Mem.</b>   |  | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>   |                           |   |   |
|   |  | 21. Signature of Funeral Service Licensee<br><b>Steve Gallas-Withey</b>   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family FH Inc.</b><br><b>4112 Old Columbia Pike Ellicott City, MD 21043</b>   |  |  |                           |   |   |
| <b>Physician/<br/>Medical<br/>Examiner</b><br><br><b>To Be Completed by Physician/Medical Examiner</b>  |  | <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)<br/><b>Pneumonia</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p><b>Congestive heart failure</b></p> <p><b>Hypertension</b></p> <p>Approximate Interval Between Onset and Death<br/><b>&gt; 1 week</b></p> <p><b>&gt; 2 years</b></p> <p>a. Due to (or as a consequence of):<br/><b>Pneumonia</b></p> <p>b. Due to (or as a consequence of):<br/><b>Congestive heart failure</b></p> <p>c. Due to (or as a consequence of):<br/><b>Hypertension</b></p> <p>d.</p>  |  |  |  |  |                           |   |   |
|   |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b> |  | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)  |                           | 23d. Date of delivery<br>Month Day Year   |   |
|   |  | <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>Hypothyroidism</b></p> <p>23e. Did tobacco use contribute to the cause of death?<br/><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b></p> <p>24a. Was an autopsy performed?<br/><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b></p>  |  |  |  |  |                           |   |   |
|   |  | <p>25. Was case referred to medical examiner?<br/><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>26. Place of Death (Check only one)<br/>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b></p> <p>27. Manner of Death<br/><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b></p> <p>28a. Date of injury (Month, Day, Year)<br/><b>M</b></p> <p>28b. Time of injury<br/><b>M</b></p> <p>28c. Injury at work?<br/><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b></p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> |  |  |  |  |                           |   |   |
|   |  | <p>29a. Certifier<br/>(Check only one)<br/><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br/><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br/><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b></p> <p>29b. Signature and title of certifier<br/><b>Dr. Rajesh</b></p> <p>29c. License number<br/><b>D0072328</b></p> <p>29d. Date signed (Month, Day, Year)<br/><b>April 28th 2012</b></p>  |  |  |  |  |                           |   |   |
|   |  | <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br/><b>RAGHURAM CHAVVA HARBOR HOSPITAL, BALTIMORE, M.D.</b></p>   |  |  |  |  |                           |   |   |
|   |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br><b>James J. Parker</b>  |  |  |                           |   |   |
| <b>Division of Vital Records, P.O. Box 68760</b><br><br><small>To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small> |  |   |  |  |  |  |                           |   |   |
| <b>State<br/>Registrar</b>  |  |   |  |  |  |  |                           |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012

15149

1- For  
State  
Registrar

|  |   |  |  |  |   |  |                                      |
|--|---|--|--|--|---|--|--------------------------------------|
| <b>Physician/<br/>Medical<br/>Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>Josephine V. Newton</b>                              |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>27</b> , Year <b>2012</b> |  | 3. Time of Death<br><b>15.20 P M</b> |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>           |  | 4c. County of Death                  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>215-46-0300</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. 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type="checkbox"/> 839<br><input type="checkbox"/> 840<br><input type="checkbox"/> 841<br><input type="checkbox"/> 842<br><input type="checkbox"/> 843<br><input type="checkbox"/> 844<br><input type="checkbox"/> 845<br><input type="checkbox"/> 846<br><input type="checkbox"/> 847<br><input type="checkbox"/> 848<br><input type="checkbox"/> 849<br><input type="checkbox"/> 850<br><input type="checkbox"/> 851<br><input type="checkbox"/> 852<br><input type="checkbox"/> 853<br><input type="checkbox"/> 854<br><input type="checkbox"/> 855<br><input type="checkbox"/> 856<br><input type="checkbox"/> 857<br><input type="checkbox"/> 858<br><input type="checkbox"/> 859<br><input type="checkbox"/> 860<br><input type="checkbox"/> 861<br><input type="checkbox"/> 862<br><input type="checkbox"/> 863<br><input type="checkbox"/> 864<br><input type="checkbox"/> 865<br><input type="checkbox"/> 866<br><input type="checkbox"/> 867<br><input type="checkbox"/> 868<br><input type="checkbox"/> 869<br><input type="checkbox"/> 870<br><input type="checkbox"/> 871<br><input type="checkbox"/> 872<br><input type="checkbox"/> 873<br><input type="checkbox"/> 874<br><input type="checkbox"/> 875<br><input type="checkbox"/> 876<br><input type="checkbox"/> 877<br><input type="checkbox"/> 878<br><input type="checkbox"/> 879<br><input type="checkbox"/> 880<br><input type="checkbox"/> 881<br><input type="checkbox"/> 882<br><input type="checkbox"/> 883<br><input type="checkbox"/> 884<br><input type="checkbox"/> 885<br><input type="checkbox"/> 886<br><input type="checkbox"/> 887<br><input type="checkbox"/> 888<br><input type="checkbox"/> 889<br><input type="checkbox"/> 890<br><input type="checkbox"/> 891<br><input type="checkbox"/> 892<br><input type="checkbox"/> 893<br><input type="checkbox"/> 894<br><input type="checkbox"/> 895<br><input type="checkbox"/> 896<br><input type="checkbox"/> 897<br><input type="checkbox"/> 898<br><input type="checkbox"/> 899<br><input type="checkbox"/> 900<br><input type="checkbox"/> 901<br><input type="checkbox"/> 902<br><input type="checkbox"/> 903<br><input type="checkbox"/> 904<br><input type="checkbox"/> 905<br><input type="checkbox"/> 906<br><input type="checkbox"/> 907<br><input type="checkbox"/> 908<br><input type="checkbox"/> 909<br><input type="checkbox"/> 910<br><input type="checkbox"/> 911<br><input type="checkbox"/> 912<br><input type="checkbox"/> 913<br><input type="checkbox"/> 914<br><input type="checkbox"/> 915<br><input type="checkbox"/> 916<br><input type="checkbox"/> 917<br><input type="checkbox"/> 918<br><input type="checkbox"/> 919<br><input type="checkbox"/> 920<br><input type="checkbox"/> 921<br><input type="checkbox"/> 922<br><input type="checkbox"/> 923<br><input type="checkbox"/> 924<br><input type="checkbox"/> 925<br><input type="checkbox"/> 926<br><input type="checkbox"/> 927<br><input type="checkbox"/> 928<br><input type="checkbox"/> 929<br><input type="checkbox"/> 930<br><input type="checkbox"/> 931<br><input 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type="checkbox"/> 963<br><input type="checkbox"/> 964<br><input type="checkbox"/> 965<br><input type="checkbox"/> 966<br><input type="checkbox"/> 967<br><input type="checkbox"/> 968<br><input type="checkbox"/> 969<br><input type="checkbox"/> 970<br><input type="checkbox"/> 971<br><input type="checkbox"/> 972<br><input type="checkbox"/> 973<br><input type="checkbox"/> 974<br><input type="checkbox"/> 975<br><input type="checkbox"/> 976<br><input type="checkbox"/> 977<br><input type="checkbox"/> 978<br><input type="checkbox"/> 979<br><input type="checkbox"/> 980<br><input type="checkbox"/> 98 |   |  |                                      |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amend 24a per dr. g927 5/11/12 kh Certificate of Death Reg. No. 2012 15150

|  |  |  |  |   |  |   |  |  |
|--|--|--|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Kelijah Bryna Nelson</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>March 29 2012</b>   | 3. Time of Death<br>9:20 PM                                 |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Civista Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Laplata</b>   |   | 4c. County of Death<br><b>Charles</b>  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>MD</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.<br><b>1 54</b>  | If Under 1 Year<br>Months Days Hours Min.<br><b>1 54</b>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 27, 2012</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|  | Usual Residence of Decedent<br><b>Prince Georges</b>   |  | 10c. City, Town or Location<br><b>Fort Washington</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince Georges</b>   | 10e. Street and Number<br><b>10834 Hill Top Drive</b>   |  | 10f. Zip Code<br><b>20744</b>                               | 10g. Citizen of What Country?<br><b>United States</b>                      |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>N/A</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>Black</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>   | 16b. Kind of Business/Industry<br><b>N/A</b>  |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Bryan Keith Nelson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tamar Shanika Smith</b>  |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Tamar NELSON/MOTHER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10834 Hill TOP DRIVE, FT. WASHINGTON, MD. 20744</b>  |   |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>CHESAPEAKE</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE</b>  | Date<br><b>4/5/2012</b>   | 20c. Location - City or Town, State<br><b>Bethesda, MD</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald J. Henry mo178</b>  |  | 22. Name and Address of Facility<br><b>B. K. Henry Funeral Home WASH. DC. 20002</b>  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Extreme prematurity, preterm delivery</b>   |  |  |   | Approximate Interval Between Onset and Death<br><b>1 hour 54 min</b>   |   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br><b>Chorioamnionitis</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. _____   |  |  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown    |   |  | 23d. Date of delivery<br>Month Day Year                     |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chorioamnionitis</b>  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Unpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                           |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>J. L. Cook</b>   |  | 29c. License number<br><b>D0066210</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 29, 2012</b>   |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>11355 PenBrooke Square, Suite 108A, Waldorf, MD 20603</b>   |  |  |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Debra J. Spaulding</b>   |   |  |   |  |  |

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State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No.

2012 15151

|  |  |  |  |  |  |   |  |   |  |   |
|--|--|--|--|--|--|---|--|---|--|---|
| Physician/<br>Medical<br>Examiner  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Cynthia Catherine Osterman</b>  |  |  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 26, 2012</b> | 3. Time of Death<br><b>8:03 P M</b>  |   |
| Funeral<br>Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Mary's Hospital</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>   |   |  | 4c. County of Death<br><b>St. Mary's</b>                    |  |   |
| To Be Completed by Funeral Director  |  | 5. Social Security Number<br><b>218-82-6555</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>50 Yrs.</b>   |   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.                         | 8. Date of Birth<br>(Month, Day, Year)<br><b>09/30/1961</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  |  | Usual Residence of Decedent<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Leonardtown</b> |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  |  | 10a. State<br><b>Maryland</b>  |  | 10e. Street and Number<br><b>42134 Medleys Neck Road</b>   |  | 10f. Zip Code<br><b>20650</b>                     |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |   |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>12</b> |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                               |  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Clyde Ellsworth Ammann</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Veronica Beall</b>   |  |   |  |   |  |   |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Diane Ammann/ Sister</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>42134 Medleys Neck Road Leonardtown, MD 20650</b>          |  |   |  |   |  |   |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Michael N Gardiner</b> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln</b>  |  |   | Date<br><b>05/02/2012</b>  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b> |  |   |
|  |  | 21. Signature of Funeral Service Person<br><b>Michael N Gardiner</b>   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home P.A.<br/>41590 Fenwick Street Leonardtown, MD 20650</b>                                |  |   |  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  | Approximate Interval Between Onset and Death<br><b>24 hrs</b>  |   |  |   |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |  |  |   |  |   |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |   |  |   |
| 23f. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23g. Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  |  | 23h. Other:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                      | 28d. Describe how injury occurred                 |  |   |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Patricia Gurny, md</b>   |  |  | 29c. License number<br><b>D26344</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 30, 2012</b>   |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PATRICIA GURNY, MD MEDSTAR ST MARY'S HOSPITAL, LEONARDTOWN, MD 20650</b>  |  |  |  |  |  |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 2012</b>  |  | 32. Registrar's Signature<br><b>J. Park</b>  |  |  |  |   |  |   |  |   |
| State<br>Registrar   |  |  |  |  |  |   |  |   |  |   |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15152

3. Time of Death

2. Date of Death  
Month Day Year  
April 25, 2012

8:55am M

Physician/  
Medical  
Examiner

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Patricia Cox Owen

4a. Facility Name (if not institution, give street and number)

9200 Persimmon Tree Road

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-32-3872

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

03/31/1924

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

9200 Persimmon Tree Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

To Be Completed by Funeral Director

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Grants Manager

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Don Gardner Cox

18. Mother's Name (First, Middle, Maiden Surname)

Frances May Chambers

19a. Informant's Name/Relationship (Type, Print)

Don Owen (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4311 Rosedale Avenue, Bethesda, MD 20814

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 4-25-2012

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

DHMH 17 Rev 06-2011

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

Immediate Cause (Final disease or condition resulting in death)

{

- a. Alzheimers Dementia  
Due to (or as a consequence of):
- b. \_\_\_\_\_  
Due to (or as a consequence of):
- c. \_\_\_\_\_  
Due to (or as a consequence of):
- d. \_\_\_\_\_

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

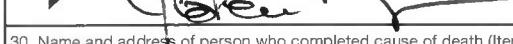
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D37142

29d. Date signed (Month, Day, Year)

April 25, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Geoffrey Coleman, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855

31. Date filed (Month, Day, Year)

APR 30 2012



32. Registrar's Signature

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15153

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5+1  
State  
Registrar

|   |  |  |   |  |  |   |  |   |
|---|--|--|---|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Fidel C. Policarpio</b>  |  |  |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 19, 2012</b>                                    | 3. Time of Death<br>Hour Minute<br><b>7:00p M</b> |
| 4a. Facility Name (if not institution, give street and number)<br><b>Casey House</b>  |  |  |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>                                       | 4c. County of Death<br><b>Montgomery</b>          |
| 5. Social Security Number<br><b>563-82-3117</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>66</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>Month Day Year<br><b>3/26/1946</b>       | 9. Birthplace (State or Foreign<br>Country)<br><b>Philippines</b> |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3150 Beethoven Way</b>   |  |  |   | 10f. Zip Code<br><b>20904</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1978</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Asian</b><br>Specify:                     |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>  |  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Naval Officer</b>   |  |   | 16b. Kind of Business/Industry<br><b>U.S. Navy</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Felix Policarpio</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ana Cruz</b>   |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Belen Policarpio/Wife</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3150 Beethoven Way Silver Spring, Md 20904</b>   |  |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington Nat'l</b>   |   | Date<br><b>6/4/2012</b>  | 20c. Location - City or Town, State<br><b>Arlington, Va.</b> |   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>PHILIP D. RINALDI FUNERAL SERVICE, P.A.<br/>9241 Columbia Blvd. Silver Spring, Md 20910</b>                               |   |  |  |   |  |   |

|   |  |  |                     |  |                                   |
|---|--|--|---------------------|--|-----------------------------------|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b>  |  | Approximate Interval Between Onset and Death   |                     |  |                                   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |                     |  |                                   |
| <p>a. Due to (or as a consequence of):<br/><br/> <br/>           b. Due to (or as a consequence of):<br/>           c. Due to (or as a consequence of):<br/>           d. Due to (or as a consequence of):</p>  |  |  |                     |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown          |                     |  |                                   |
| 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                     |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                     |  |                                   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b> |                     |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |                                   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D37142</b>   |                     | 29d. Date signed (Month, Day, Year)<br><b>April 19, 2012</b>                           |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. Coleman MD 6001 Muncaster Mill Rd Rockville, Md 20855</b>   |  |  |                     |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br>  |                     |  |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15154

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Pool, Harold

Baltimore, Maryland 21215-0036

|   |  |   |                                |  |  |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |                                | 3. Time of Death<br>M  |  |
| <b>HAROLD E POOLE</b>   |  | <b>April 19 2012</b>  |                                | <b>1306</b>  |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                                | 4c. County of Death  |  |
| <b>Baltimore Washington Medical Center</b>  |  | <b>St. Barnabas</b>   |                                | <b>Anne Arundel</b>  |  |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | 8. Date of Birth<br>(Month, Day, Year)   |  |
| <b>219-50-1147</b>  |  | <b>1 X M 2 <input type="checkbox"/> F</b>   | <b>65 Yrs.</b>                 | <b>Feb 11 1947</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>    |
| 10a. State  |  | 10b. County   | 10c. City, Town or Location    |  |  |
| <b>Maryland</b>   |  | <b>Anne Arundel</b>   | <b>Severna Park</b>            |  |  |
| 10e. Street and Number  |  | 10f. Zip Code   |                                |  | 10g. Citizen of What Country?                                  |
| <b>511 Retford Dr.</b>  |  | <b>21146</b>  |                                |  | <b>USA</b>   |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <b>X</b> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input type="checkbox"/> Yes 2 <b>X</b> No<br>If Yes, Give Year or Dates.  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <b>X</b> No Specify: |  |
|   |  |   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) <b>12th</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br><b>Janitorial</b>   |                                | 16b. Kind of Business/Industry<br><b>Spectacular Cleaning Service Inc</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><br><b>Rufus Poole</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><br><b>Martha G. Johnson</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><br><b>Cynthia Poole (Wife)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br><b>511 Retford Dr. Severna Park, Md. 21146</b>   |                                |  |  |
| 20a. Method of Disposition<br><br>1 <b>X</b> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br><b>St. Rest</b>   |                                | Date<br><b>4-28-12</b>   | 20c. Location - City or Town, State<br><br><b>Hanover, Md.</b> |
| 21. Signature of Funeral Service Licensee<br><br><b>Terry A. Poole</b>  |  | 22. Name and Address of Facility<br><br><b>W.H. Reese &amp; Sons Mortuary, P.A.</b><br><b>1922 Forest Dr. Annapolis, Md. 21401</b>  |                                |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |                                |  |  |
| a. <b>CARDIOGENIC SHOCK</b><br>Due to (or as a consequence of):   |  |   |                                |  |  |
| b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):   |  | <b>YEARS</b>  |                                |  |  |
| c. _____<br>Due to (or as a consequence of):  |  |   |                                |  |  |
| d. _____  |  |   |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DIABETES</b><br><b>HYPERTENSION</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><br>1 <input type="checkbox"/> Yes 2 <b>X</b> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <b>X</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <b>X</b> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                            |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <b>X</b> No   |  |
| 27. Manner of Death<br><br>1 <b>X</b> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury            | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred                              |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><br><b>Chawna Samethi</b>  |  | 29c. License number<br><br><b>DO 051325</b>   |                                | 29d. Date signed (Month, Day, Year)<br><br><b>4/20/12</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><br><b>CHAWNA SAMETHI, 1600 CRAN Hwy, STE 501, GLEN BURNIE, MD 21061</b>  |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><br><b>APR 26 2012</b>   |  | 32. Registrar's Signature<br><br><b>Chawna S. Samethi</b>   |                                |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend 23b, 24a-b, 25, 26, 27, per phy, g927 5-11-12 sm  
 State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15155

Physician/  
Medical  
Examiner

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| Mildred Anna Pugh                        | April 28 2012                      | 6:12 AM          |

4a. Facility Name (if not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

|                           |  |   |   |                                |  |  |
|---------------------------|--|---|---|--------------------------------|--|--|
| 5. Social Security Number | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>97 Yrs. | If Under 1 Year<br>Months Days Hours Min. | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>June 4, 1914 | 9. Birthplace (State or Foreign Country)<br>Maryland |
|---------------------------|--|---|---|--------------------------------|--|--|

Usual Residence of Decedent

Maryland

10b. County  
Cecil

10c. City, Town or Location  
Perryville

10d. Inside City Limits  
 Yes  No

10e. Street and Number

385 Poplar Point Road

10f. Zip Code

21903

10g. Citizen of What Country?

United States

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Her Own Home

17. Father's Name (First, Middle, Last)

Howard Krauss

18. Mother's Name (First, Middle, Maiden Surname)

Martha Heath

19a. Informant's Name/Relationship (Type, Print)

Martha Peterson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 450, Charlestown, MD 21914

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, cemetery or other place)

Cherry Hill  
Methodist Cemetery

Date

May 1,  
2012

20c. Location - City or Town, State

Cherry Hill, MD

21. Signature of Funeral Service Licensee

► Joseph L. Kerns

22. Name and Address of Facility

Hicks Home for Funerals, P.A.  
103 W. Stockton Street, Elkton, MD 21921

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

4 days

a. Right lower extremity ischemia

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

1  Yes 2  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

24a. Was an autopsy performed?  
 Yes  No

24b. Were autopsy findings available prior to completion of cause of death?  
 Yes  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Michelle Kerns, MD

29c. License number

1821388976  
K101684

29d. Date signed (Month, Day, Year)

April 28, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Kerns 22 South Greene Street Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature

► Jennifer D. Parker

To Be Completed by Funeral Director  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15156

1 - For  
State  
Registrar

|  |  |  |   |  |   |   |  |  |
|--|--|--|---|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>William Francis Pursley</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>30</b> Year <b>2012</b>   | 3. Time of Death<br>1637 PM                                   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>471 Elk Mills Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  | 4c. County of Death<br><b>Cecil</b>   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-26-8963</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>88</b><br>Yrs.   | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> | If Under 24 Hrs.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT 17, 1923</b> | 9. Birthplace (State or Foreign<br>Country)<br><b>Maryland</b>   |  |
|  | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>Elkton</b>   |  |   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>471 Elk Mills Road</b>  |  |   | 10f. Zip Code<br><b>21921</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>         |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>World War II</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b>  | 14. Race - American Indian, Black, White, etc.                                   |   |   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Mailman</b>                       | 16b. Kind of Business Industry<br><b>United States Postal Service</b>   |  |   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William P. Pursley</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella Butler</b>        |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Grace Pursley/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>471 Elk Mills Road, Elkton, MD 21921</b>  |  |   |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Donald S. Hicks</b>  |  | 20b. Place of Disposition (Name of Cemetery, Cemetery or other place)<br><b>Immaculate Conception Cemetery</b>  | Date<br><b>May 3, 2012</b>   | 20c. Location - City or Town, State<br><b>Cherry Hill, MD</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner                      | 21. Signature of Funeral Service Licensee<br><b>Donald S. Hicks</b>  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921</b>   |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |  |   |  |   |   | Approximate Interval Between Onset and Death<br><b>1 yr.</b>   |  |
|  | b. Due to (or as a consequence of):<br><b>Cerebrovascular accident</b>   |  |   |  |   |   | <b>5 yr.</b>   |  |
|  | c. Due to (or as a consequence of):<br><b>Hypertension</b>   |  |   |  |   |   | <b>10 yr.</b>  |  |
|  | d.   |  |   |  |   |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Insufficiency</b><br><b>Depression</b><br><b>Hypercholesterolemia</b>   |  |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br>Other:<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Barbara A. Parey, M.D.</b>   |  | 29c. License number<br><b>025915</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5-1-2012</b>  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 2a) (Type, Print)<br><b>Barbara A. Parey, M.D., 111 W. High Street, Suite 214, Elkton, MD 21921</b>  |  |   |  |   |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>J. Parker</b>   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15157

1 - For  
State  
Registrar

|  |   |  |  |   |   |  |  |
|--|---|--|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Panchula</b>   |  |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> , Year <b>2012</b>         | 3. Time of Death<br>A.M. <b>0915</b> M   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |   |   | 4c. County of Death<br><b>Washington</b>                                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>282-20-1391</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs.  | If Under 1 Year<br>Months      Days      Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug. 18, 1924</b>  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                      |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Smithsburg</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>13810 Frank's Run Rd.</b>  |  |  | 10f. Zip Code<br><b>21783</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A</b>                                |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify: <b>X</b> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Alex Krall</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Hruba</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ellen M. Panchula (Daughter)</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13810 Frank's Run Rd. Smithsburg, Md. 21783</b>   |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of Facility, Cemetery, etc.)<br><b>Smithsburg Crematory</b>  |   | Date<br><b>May 7, 2012</b>  | 20c. Location - City or Town, State<br><b>Smithsburg, Md.</b>                |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>J.L. Davis</b>  |  | 22. Name and Address of Facility<br><b>M01414 J.L. Davis Funeral Home</b>  |   | 12525 Bradbury Ave.<br>Smithsburg, Md. 21783  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |   |   |  |  |
|  | <p>a. Due to (or as a consequence of): <b>Acute lymphocytic leukemia</b></p> <p>b. Due to (or as a consequence of): <b>Chronic lymphocytic leukemia</b></p> <p>c. Due to (or as a consequence of): <b>Atrial fibrillation</b></p> <p>d. _____</p>   |  |  |   |   |  |  |
|  | Approximate Interval Between Onset and Death  |  |  |   |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) |   |   | 23d. Date of delivery<br>Month Day Year                                      |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
|  | 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Amstler</b>   |  |  | 29c. License number<br><b>D0070027</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/5/2012</b>                       |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Haizua Amstler, MD 11116 Medical Campus Rd. Hagerstown, MD 21742</b>   |  |  |   |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |  | 32. Registrar's Signature<br><b>Haizua J. Amstler</b>  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*6pm*

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15158

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| <b>Pauline ROZIER</b>                    | 4 17 2012                          | 12:06 P M        |

**Funeral  
Director**

|  |  |                                |  |  |
|--|--|--------------------------------|--|--|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death                                 |                                |  |  |
| <b>Gilchrist Center</b>  | <b>Towson</b>  |                                |  |  |
| 5. Social Security Number                                      | 6. Sex   | 7. Age (in yrs. last birthday) | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| <b>212-14-4006</b>   | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | <b>94</b> Yrs.                 | <b>1-1-1918</b>                        | <b>Centreville<br/>Maryland</b>          |

Usual Residence of Decedent

|                          |                       |                               |  |
|--------------------------|-----------------------|-------------------------------|--|
| 10a. State               | 10b. County           | 10c. City, Town or Location   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>MD</b>                | <b>Baltimore City</b> | <b>Baltimore</b>              |  |
| 10e. Street and Number   | 10f. Zip Code         | 10g. Citizen of What Country? |  |
| <b>4804 Gilray Drive</b> | <b>21214</b>          | <b>USA</b>                    |  |

To Be Completed by Funeral Director

|  |   |   |   |
|--|---|---|---|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |   |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)                                      | 16b. Kind of Business/Industry  |   |
| <b>Elementary/Secondary (0-12)</b>   | <b>Housekeeping</b>   | <b>Domestic Engineers</b>   |   |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| <b>William Scott</b>                    | <b>Hillie Mac Emory</b>                           |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| <b>HENRIETTA PINCKNEY, Sister</b>                | <b>4804 Gilray Drive, Baltimore, MD 21214</b>   |

|   |  |                  |                                     |
|---|--|------------------|-------------------------------------|
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date             | 20c. Location - City or Town, State |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | <b>Chestertown Cemetery</b>  | <b>4/24/2012</b> | <b>Chestertown, MD</b>              |

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility                                      |
| <b>Dornell</b>                            | <b>426 East Dover Street<br/>Berne Smith Funeral Home, EASTON, MD</b> |

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. <b>Sepsis</b><br>Due to (or as a consequence of):   |  |
| b. <b>Decubitus Ulcer infection</b><br>Due to (or as a consequence of):  |  |
| c. Due to (or as a consequence of):  |  |
| d. Due to (or as a consequence of):  |  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Pulmonary Embolism</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |   |
|---|---|
| 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|---|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |
|---|---|

|   |  |                          |  |                                   |
|---|--|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|---|--|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
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|--|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
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|  |  |   |
|--|--|---|
| 29b. Signature and title of certifier<br><b>M.D.</b> | 29c. License number<br><b>D0071287</b> | 29d. Date signed (Month, Day, Year)<br><b>4-18-12</b> |
|--|--|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |
| <b>Philip Shaheen, 6701 N. Charles St. # 4105, Baltimore, MD 21204</b>               |

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>APR 23 2012</b> | 32. Registrar's Signature<br><b>Laura D. Jones</b> |
|---|--|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RS 3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15159

1-  
For  
State  
Registrar

|  |  |  |   |  |  |   |  |  |  |   |  |                                   |  |  |
|--|--|--|---|--|--|---|--|--|--|---|--|-----------------------------------|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Jose Gustavo Reyes</b>  |  |   |  |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>20</b> , Year <b>2012</b>  | 3. Time of Death<br>1613 M                                 |  |   |  |                                   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  |   | 4c. County of Death<br><b>Montgomery</b>   |  |  |   |  |                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-17-5603</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>3/25/1957</b> | 9. Birthplace (State or Foreign<br>Country)<br><b>El Salvador</b>                              |   |  |                                   |  |  |
|  | Usual Residence of Decedent<br><b>MD Montgomery</b>  |  | 10a. State<br>10b. County<br><b>Montgomery</b>  |  |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |                                   |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>911 Hoyt Street</b>   |  |   | 10f. Zip Code<br><b>20902</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |  |                                   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>El Salvadoran</b>                                    |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |                                   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Contractor</b>  |  |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |   |  |                                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Eugenio Reyes</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elena Fernandez</b>  |  |   |  |  |  |   |  |                                   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elsa Reyes/Wife</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>911 Hoyt Street Silver Spring, Md 20902</b>  |  |   |  |  |  |   |  |                                   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven</b>   |  |  | Date<br><b>4/28/2012</b>  | 20c. Location - City or Town, State<br><b>Silver Spring, Md</b>  |  |  |   |  |                                   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 21a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PHILIP RINALDI FUNERAL SERVICE, P.A.<br/>9241 Columbia Blvd. Silver Spring, Md 20910</b> |  |   |  |  |  |   |  |                                   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardio Pulmonary arrest</b><br>Due to (or as a consequence of):<br><b>Stroke with hemorrhagic transformation</b>  |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |   |  |                                   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. <b>Cardio Pulmonary arrest</b><br>Due to (or as a consequence of):<br><b>Stroke with hemorrhagic transformation</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |  |   |  |  |  |   |  |                                   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |                                   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |  |                                   |  |  |
|  |  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)              |  |  | 27. Manner of Death<br><b>Natural</b><br><input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |
|  |  |  |   |  |  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |  |  |  |   |  |                                   |  |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D65069</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>  |  |  |  |   |  |                                   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sirak Lemma MD 1500 Forest Glen Rd Silver Spring, Md 20910</b>  |  |   |  |  |   |  |  |  |   |  |                                   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |   |  |                                   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

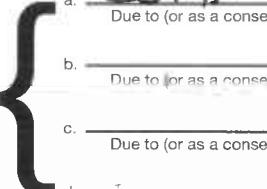
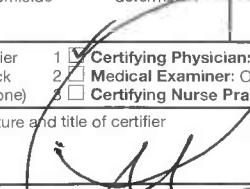
Certificate of Death

Reg. No.

2012 15160

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month<br>April  |  | 3. Time of Death<br>Day<br>19, 2012<br>Year<br>10:00 AM                          |
| Marjorie Elizabeth Ricker  |  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Atlantic General Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>   |  | 4c. County of Death<br><b>Worcester</b>  |
| 5. Social Security Number<br><b>381-12-6612</b><br>Usual Residence of Decedent   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>90 Yrs.  | 8. If Under 24 Hrs.<br>Months<br>Hours<br>Min.                                   |
|  |  |   |  | 9. Date of Birth<br>(Month, Day, Year)<br><b>02/03/1922</b>                      |
|  |  |   |  | 10. Birthplace (State or Foreign Country)<br><b>Michigan</b>                     |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Worcester</b>   | 10c. City, Town or Location<br><b>Ocean City</b>   |  |
|  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>602 Twin Tree Road</b>  |  | 10f. Zip Code<br><b>21842</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Ticketing Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Railroad</b>                                |
| 17. Father's Name (First, Middle, Last)<br><b>Archie Harris</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Seiffert</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dave Ricker / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12730 Springfield Court, Dunkirk, Maryland 20754</b>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b>  | Date<br><b>04-23-2012</b>  | 20c. Location - City or Town, State<br><b>Edgewater, Maryland</b>                |
| 21. Signature of Funeral Director/Attending Physician<br>   |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Rd., Edgewater, MD 21037</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COPD</b>  |  |   |  |  |
| Approximate Interval Between Onset and Death   |  |   |  |  |
| a. Due to (or as a consequence of):<br><b>COPD</b>   |  |   |  |  |
| b. Due to (or as a consequence of):  |  |   |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)        |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D53612</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/19/2012</b>                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrea K. Baier, M.D 9733 Healthway Drive, Berlin, Maryland 21811</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1516

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at once.

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death<br>Month 04 Day 21 Year 12 1920 M   |   |  |  | 3. Time of Death<br>1920 M                                       |  |
| RACIETL ROUSE   |  |   |  |   |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>Anne Arundel Medical Center   |  |   | 4b. City, Town, or Location of Death<br>Annapolis  |   |  |  | 4c. County of Death<br>Anne Arundel                              |  |
| 5. Social Security Number<br>239-24-7400  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                | 8. Date of Birth<br>(Month, Day, Year)<br>12/07/1920             | 9. Birthplace (State or Foreign Country)<br>North Carolina   |
| Usual Residence of Decedent<br>MD   |  | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Annapolis |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>130 Hearne Road # 610   |  |   |  | 10f. Zip Code<br>21401  |  |  | 10g. Citizen of What Country?<br>USA                             |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) 01               |   | Bookeeper  |  |  | 16b. Kind of Business/Industry<br>Hardware   |
| 17. Father's Name (First, Middle, Last)<br>Roscoe Pierce  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Plina Sandlin |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia R. McGarty Daughter  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1866 Baltimore & Annapolis Blvd Annapolis, MD 21409 |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Atlantic Crematory   |   |  | Date<br>04/23/2012                       | 20c. Location - City or Town, State<br>Glen Burnie, MD           |  |
| 21. Signature of Funeral Service Licensee<br>► <i>Dale J. Galt</i>  |  |   | 22. Name and Address of Facility<br>Hardesty Funeral Home P.A. Annapolis, MD 21401<br>12 Ridgely Ave   |   |  |  |  |  |

|  |  |  |   |
|--|--|--|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  | Approximate Interval Between<br>Second and Death<br>OTHERS DAYS YEARS |
| <p>a. Due to (or as a consequence of):<br/><i>Acute respiratory failure</i></p> <p>b. Due to (or as a consequence of):<br/><i>Aspiration pneumonia</i></p> <p>c. Due to (or as a consequence of):<br/><i>Dementia</i></p> <p>d.</p>  |  |  |   |

|   |  |   |  |  |   |  |  |
|---|--|---|--|--|---|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year |  |  |
|---|--|---|--|--|---|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|--|--|--|--|--|--|--|--|

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |  | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|---|--|---|--|---|--|--|--|

|   |  |  |  |  |  |                                   |  |
|---|--|--|--|--|--|-----------------------------------|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Michael J. Lentz</i> |  |  |  |  |  |
|---|--|--|--|--|--|--|--|

|   |  |                               |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>MICHAEL J. LENTZ</i> |  | 29c. License number<br>021438 |  |  | 29d. Date signed (Month, Day, Year)<br>April 22 2012 |  |  |
|---|--|-------------------------------|--|--|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 31. Date filed (Month, Day, Year)<br>APR 26 2012 |  | 32. Registrar's Signature<br><i>Leanne S. Parker</i> |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15162

**1 - For  
State  
Registrar**

**Physician/  
Medical  
Examiner**

|   |  |  |  |   |   |   |  |  |  |  |
|---|--|--|--|---|---|---|--|--|--|--|
| <b>Funeral<br/>Director</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES SANGER</b>  |  |  |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>11</b> Year <b>2012</b> | 3. Time of Death<br><b>11:18 P M</b>   |  |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b> |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>MARYLAND</b>                                |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>  | 5. Social Security Number<br><b>215-38-0767</b>  |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>75 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>9/26/1936</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>    |  |  |
|   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>TALBOT</b>   |   | 10c. City, Town or Location<br><b>CORDOVA</b>   |   |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                   |  |  |
| 10e. Street and Number<br><b>11745 KITTY'S CORNER ROAD</b>  |  |  |  | 10f. Zip Code<br><b>21625</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married</b>  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates.    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b> |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 0 POSTMASTER</b> |   |   | 16b. Kind of Business/Industry<br><b>UNITED STATES POSTAL SERVICE</b>                            |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>C. EDGAR SCHWANINGER</b>  |  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LEILA E. CHERBONNIER</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BETTY ANN SANGER, WIFE</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11745 KITTY'S CORNER ROAD, CORDOVA, MD 21625</b>    |   |   |  |  |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State</b>  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAIRVIEW CEMETERY</b> |   | Date<br><b>4/26/2012</b>  | 20c. Location - City or Town, State<br><b>CORDOVA, MARYLAND</b>       |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>► JOHN R. MERCERON</b>  |  |  |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A.<br/>200 SOUTH HARRISON STREET, EASTON, MD 21601</b>          |   |   |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  |  | Approximate Interval Between Onset and Death<br><b>4 YEARS</b>  |   |   |  |  |  |  |
| <p>a. <b>METASTATIC COLON CANCER</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |  |  |   |   |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No</b><br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy<br/>4 Pregnant at time of death 5 Other (specify) 9 Unknown</b> |  |   |   |   | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |  |  |
|   |  |  |  |   |   |   | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  |  |  |
|   |  |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  | Hospital:<br><b>1 Inpatient 2 ER/Outpatient 3 DOA</b>  |  |   | 26. Place of Death (Check only one)<br><b>Other: 4 Nursing Home 5 Residence 6 Other (Specify)</b>   |   |  |  |  |  |
| 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  |   | 28c. Injury at work?<br><b>1 Yes 2 No</b>                             |  | 28d. Describe how injury occurred                              |  |  |
|   |  |  |  |   |   |   |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                     |  |  |  |
| 29a. Certifier<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>► KAMINI PATEL RESIDENT PHYSICIAN</b>   |  | 29c. License number<br><b>1265731483</b>   |  |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 14, 2012</b>                                     |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KAMINI PATEL 22 S. GREENE ST. BALTIMORE, MD 21201</b>  |  |  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 19 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne S. Patel</b>  |  |   |   |   |  |  |  |  |

**Baltimore, Maryland 21215-0036**

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2012 15163

Physician/  
Medical  
ExaminerFuneral  
Director

Baltimore, Maryland 21215-0036  
 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  |   | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death                         |  |   |
| <b>Arthur Heinrich Gerhard Scharfenstein</b>   |  |   | April 26, 2012   |  | 9:00 p.m. <sup>M</sup>                   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Hospice House of St. Mary's</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Callaway</b>  |  | 4c. County of Death<br><b>St. Mary's</b> |  |   |
| 5. Social Security Number<br><b>577-72-8365</b>  |  | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>82</b><br>Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days                 | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/15/1929</b>      | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>              |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Hollywood</b>  |  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>                        |
| 10e. Street and Number<br><b>24634 Greenview Drive</b>   |  |   | 10f. Zip Code<br><b>20636</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>            |   |
| 11. Marital Status<br>1 □ Never Married 2 X Married<br>3 □ Widowed 4 □ Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 □ Yes 2 X No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>2</b> |  | 16b. Kind of Business/Industry<br><b>Cabinet Maker</b>   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Heinrich Scharfenstein</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Knipper</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Karin Paz/Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24634 Greenview Drive, Hollywood, MD 20636</b> |  |  |  |   |
| 20a. Method of Disposition<br>1 □ Burial 2 X Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)<br><br>Brinsfield-Echols Cre |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols</b>   |  | Date<br><b>04/28/2012</b>                | 20c. Location - City or Town, State<br><b>Charlotte Hall, MD</b> |   |
| 21. Signature of Funeral Service licensee<br><br>Edward N. Brinsfield, Jr. M00052  |  |   | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650</b>                               |  |  |  |   |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760  
 To Be Completed by Physician/Medical Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |   |  |   |
|--|--|--|--|---|--|---|--|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown     |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |  | 23d. Date of delivery<br>Month Day Year |  | Approximate Interval Between Onset and Death  |
|  |  |  |  |   |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 X Yes 2 □ No 3 □ Probably 4 □ Unknown |
|  |  |  |  |   |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   |  | Hospital:<br>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA                                   |  | 26. Place of Death (Check only one)<br>Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) <b>Hospice house</b>   |  |   |  |   |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 □ Yes 2 □ No | 28d. Describe how injury occurred       |  |   |
|  |  |  |  |   |  |   |  |   |
| 29a. Certifier<br>(Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |
| 29b. Signature and title of certifier<br><br><b>Jennifer Schmidt, D.O.</b>   |  | 29c. License number<br><b>M0055751</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 27, 2012</b>  |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>                                |  | 32. Registrar's Signature<br><b>Susan S. Parker</b>   |  |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15164

For  
State  
Registrar

Physician  
/Medical  
Examiner

\* Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

M 410385

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |   |  |                                       |
|--|--|--|--|--|--|---|--|---------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Allen Swann</b>  |  |  |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 26 2012 11:52 PM</b>  | 3. Time of Death                      |
| 4a. Facility Name (If not institution, give street and number)<br><b>CIVISTA MEDICAL CENTER</b>  |  |  |  |  |  |   | 4b. City, Town, or Location of Death<br><b>LA PLATA</b>  | 4c. County of Death<br><b>CHARLES</b> |
| 5. Social Security Number<br><b>215-46-2739</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>65 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>02/22/1947</b>     | 9. Birthplace (State or Foreign Country)<br><b>La Plata, MD</b>  |                                       |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Charles</b>  |  | 10c. City, Town or Location<br><b>Newburg</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                       |
| 10e. Street and Number<br><b>9800 Meadowview Drive</b>   |  |  |  | 10f. Zip Code<br><b>20664</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                       |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1965</b>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |                                       |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>9th</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Pipefitter</b>  |  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |   |  |                                       |
| 17. Father's Name (First, Middle, Last)<br><b>Wilson Edward Swann</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Agnes Wise</b>   |  |   |  |                                       |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dena M. Carr / Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15520 Baden-Naylor Rd., Brandywine, MD 20613</b> |  |   |  |                                       |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Trinity Memorial Gardens</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Memorial Gardens</b>  |  |  | Date<br><b>05/03/2012</b>  | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b> |  |                                       |
| 21. Signature of Funeral Service Licensee<br><b>Brinsfield-Echols F.H., P.A.<br/>#M00817</b>   |  |  |  | 22. Name and Address of Facility<br><b>30195 Three Notch Rd., Charlotte Hall, MD 20622</b>   |  |   |  |                                       |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiopulmonary Arrest</b>  |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |                                       |
| b. Due to (or as a consequence of):<br><b>Acute Myocardial infarction</b>  |  |  |  |  |  |   |  |                                       |
| c. Due to (or as a consequence of):  |  |  |  |  |  |   |  |                                       |
| d. Due to (or as a consequence of):  |  |  |  |  |  |   |  |                                       |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                       |
|  |  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                       |
|  |  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                       |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                       |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural<br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day Year)   |  | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                               |  |                                       |
|  |  |  |  |  |  |   |  |                                       |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |                                       |
| 29b. Signature and title of certifier<br><b>C. Asensio</b>   |  | 29c. License number<br><b>DS4550</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/27/12</b>  |   |  |                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>For E. Charles St La Plata, MD 20646</b>  |  |  |  |  |  |   |  |                                       |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 2012</b>  |  | 32. Registrar's Signature<br><b>Jeanne S. Parks</b>  |  |  |  |   |  |                                       |

## Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a & show any injury or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: AMEND#4c+23perMD, 5/1/12; BMW, MoCo

Certificate of Death

Reg. No.

2012 15165

|  |   |   |   |  |  |   |  |  |  |  |   |
|--|---|---|---|--|--|---|--|--|--|--|---|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Ricardo Sanchez</i>  |   |   |  |  |   |  | 2. Date of Death<br>Month<br>4 Day<br>27 Year<br>12 1945 M                                     | 3. Time of Death                               |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Bon Secours Hospital - Baltimore</i> |   |   |  |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                                       | 4c. County of Death<br><i>Baltimore County</i> |  |   |
| Funeral Director   | 5. Social Security Number<br>None   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>46 Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br>07/14/1965  | 9. Birthplace (State or Foreign Country)<br>Honduras |  |  |  |   |
| Usual Residence of Decedent  |   |   |   |  |  |   |  |  |  |  |   |
| 10a. State<br>Md   |   | 10b. County   |   | 10c. City, Town or Location<br><i>Baltimore</i>  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |
| 10e. Street and Number<br><i>311 S. Calhoun St.</i>  |   |   |   |  | 10f. Zip Code<br><i>21223</i>  |   |  | 10g. Citizen of What Country?<br><i>Honduras</i>   |  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><i>1968</i>  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Specify: <i>Honduras</i> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Hispanic</i>                     |  |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>12th</i>  |   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Labor</i> |  |   |  | 16b. Kind of Business/Industry<br><i>Construction</i>  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><i>Ricardo Javier Sanchez</i>   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Francisca Alfaro</i>   |   |  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Olvin Sanchez/Son</i>   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>311 S. Calhoun St. Baltimore, Md. 21223</i>  |   |  |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>General Cemetery</i>   |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>General Cemetery</i>                            |  |   | Date<br>05/07/12                                     | 20c. Location - City or Town, State<br><i>Honduras</i>   |  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Sebastien</i>  |   |   |   |  | 22. Name and Address of Facility John T. Rhines Funeral Home<br><i>3005 12th. St. NE Washington D.C. 20017</i>   |   |  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |   |  |  |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br><i>anoxic encephalopathy</i>  |   |   |   |  |  |   |  |  |  |  |   |
| Approximate Interval Between Onset and Death   |   |   |   |  |  |   |  |  |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |  |   |  |  |  |  |   |
| <p>a. <i>anoxic encephalopathy</i><br/>Due to (or as a consequence of):</p> <p>b. <i>cirrhosis</i><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |   |  |  |   |  |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |  |   |  |  | 23d. Date of delivery<br>Month Day Year        |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of Injury<br>(Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |   |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Michael Doff, MD</i>  |   |  |  |   |  |  |  | 29c. License number<br><i>D65350</i>   | 29d. Date signed (Month, Day, Year)<br><i>4/27/12</i>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>2005 w. Baltimore St., Baltimore, MD 21223</i>  |   |   |   |  |  |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>APR 30 2012</i>  |   | 32. Registrar's Signature<br><i>Sandra S. Gandy</i>   |   |  |  |   |  |  |  |  |   |

For  
State  
Registrar: 1- AMEND#4c+23perMD, 5/1/12; BMW, MoCo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15166

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |  |  |  |  |   |  |  |   |
|-------------------------------------|--|--|--|--|--|---|--|--|---|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph S. Sudo</b>  |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> , Year <b>2012</b>   |  | 3. Time of Death<br><b>11:08 A M</b>   |   |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>1616 Trawler Lane</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>514-17-1597</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>12</b> Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 03, 1999</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Kansas</b>   |
| To Be Completed by Funeral Director |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Annapolis</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|                                     |  | 10e. Street and Number<br><b>1616 Trawler Lane</b>   |  |  |  | 10f. Zip Code<br><b>21409</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|                                     |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|                                     |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |   |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Sudo</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Suzanne Lawson</b>  |  |  |   |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Sudo / Father</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1616 Trawler Lane Annapolis, MD 21409</b>   |  |  |   |
|                                     |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, INC.</b>  |  | Date<br><b>April 30, 2012</b>  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |
|                                     |  | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146</b>  |  |  |   |
|                                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  |  | Approximate Interval Between Onset and Death  |  |  |   |
|                                     |  | <p>a. <i>Cerebral Herniation due to hydrocephalus</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Malignant Rhabdoid tumor</i><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>  |  |  |  | <i>5 years</i>  |  |  |   |
|                                     |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  |   |  | 23d. Date of delivery<br>Month Day Year  |   |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Malignant Rhabdoid tumor</i>  |  |  |  |   |  |  |   |
|                                     |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |  |   |
|                                     |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
|                                     |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |
|                                     |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
|                                     |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D 68607</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/12</b>   |  |  |   |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Matthew Trucco MD Johns Hopkins Hospital 600 N. Wolfe St. Baltimore MD</i>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br><i>Anne S. Park</i>  |  |  |   |

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15167

Physician/  
Medical  
Examiner1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Robert M. Stock

2. Date of Death

Month  
AprilDay  
25, 2012Year  
12:10p M

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral  
Director

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

904 Randell Road

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

097-22-7717

6. Sex

1  M 2  F

7. Age (in yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 13, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

904 Randell Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.  
1946-1949

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Merrill Stock

18. Mother's Name (First, Middle, Maiden Surname)

Erna Habermann

19a. Informant's Name/Relationship (Type, Print)

Rosie Stock / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

904 Randell Road Severna Park, MD 21146

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

May 01, 2012

20c. Location - City or Town, State

Crpwnsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Ritchie Hwy, Severna Park, MD 21146

Approximate Interval Between Onset and Death

5 years

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STROKE

a. Due to (or as a consequence of):

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death  
4  Pregnant at time of death  
9  Unknown3  Ectopic pregnancy  
5  Other (Specify) \_\_\_\_\_23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical examiner?  
1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural  
2  Accident  
3  Suicide  
4  Homicide5  Pending Investigation  
6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20094

29d. Date signed (Month, Day, Year)

04/26/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELLIOTT Gorbatyay 1411 Madison Park Drive, Glen Burnie, Md, 21060

31. Date filed (Month, Day, Year)

APR 26 2012

32. Registrar's Signature

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

AMEND#23a Per PHY State of Maryland / Department of Health and Mental Hygiene  
1- State 4/26/2012 AAO HEALTH DEPT. CMH Certificate of Death Reg. No.

2012 15168

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| Physician/<br>Medical<br>Examiner  |  | Baltimore, Maryland 21215-0036   |  |   |  |   |  | Division of Vital Records, P.O. Box 68760  |  |   |  |
|  |  | Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |  |   | Reg. No.   |   | Date of Death<br>Month Day Year  |  | 3. Time of Death   |   |  |
| Funeral<br>Director  |  | Mary H. Stockard   |  |   | APRIL 21, 2012 0930 A M  |   |  |  |  |   |  |
| To Be Completed by Funeral Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |   |  |
|  |  | 5. Social Security Number<br><b>218-20-2440</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>94</b><br>Yrs.   |  | If Under 1 Year<br>Months      Days      Hours      Min.                                       |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 20, 1918</b>         |  |
|  |  | Usual Residence of Decedent  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Millersville</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                 |  |
|  |  | 10e. Street and Number<br><b>404 Saddleback Court</b>  |  | 10f. Zip Code<br><b>21108</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>2</b>     |  |   | Nurse  |  |  | 16b. Kind of Business/Industry<br><b>Health Care</b>                    |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Fred Herman</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Beehner</b>   |  |   |  |  |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan L. Cochrane / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 Saddleback Court Millersville, MD 21108</b> |  |   |  |  |  |   |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  |   | Date<br><b>April 24, 2012</b>  |  | 20c. Location - City or Town, State<br><b>Suitland, MD</b> |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Ritchie Hwy, Severna Park, MD 21146</b>          |  |   |  |  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><b>RESPIRATORY FAILURE</b><br><b>ASPIRATION</b> Terminal Aspiration   |  |   |  |   | Approximate Interval Between Onset and Death   |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><b>DEMENTIA</b><br><b>DYSPHAGIA</b>   |  |   |  |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____                                    |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b><br><b>DYSPHAGIA</b>  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural<br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>H54409</b>   |  |   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 21, 2012</b>                                   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BENJAMIN MALKIEL 110 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21060</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br>                                    |  |   |  |  |  |   |  |

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## **Medical Certificate: To Be Completed by Physician/Medical Examiner**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

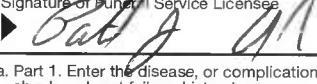
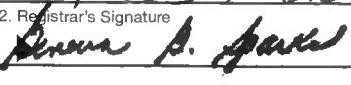
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15169

|   |  |  |  |  |   |   |  |  |  |  |   |   |  |
|---|--|--|--|--|---|---|--|--|--|--|---|---|--|
| 1 - For State Registrar                       |  | 1. Decedent's Name (First, Middle, Last)<br><b>Martha Elaine Smith</b>   |  |  |   |   |  | 2. Date of Death<br>Month <b>04</b> Day <b>24</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>5:40P M</b>                                 |   |   |  |
| Physician/ Medical Examiner                   |  | 4a. Facility Name (if not institution, give street and number)<br><b>407 Halsey Road</b>   |  |  |   |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                         |   |   |  |
| Funeral Director                              |  | 5. Social Security Number<br><b>577-48-6576</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                   |   | 7. Age (In yrs. last birthday)<br><b>75</b><br>Yrs.   |  | If Under 1 Year<br>Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>  |  | 8. Date of Birth<br>Month <b>01</b> Day <b>16</b> Year <b>1937</b> |   |   |  |
| To Be Completed by Funeral Director           |  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, MD</b>   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 10a. State<br><b>MD</b>  |  |  |   |   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Annapolis</b>                    |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>407 Halsey Road</b>   |  |  |   |   |  | 10f. Zip Code<br><b>21401</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                        |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:          |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Assistant</b>  |   |  | 16b. Kind of Business Industry<br><b>Real Estate</b>   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Franklin Fisher</b>  |  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Wells</b>   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John A. Smith Spouse</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 Halsey Road Annapolis, MD 21401</b>   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |   |  | Date<br><b>04/25/2012</b>  |  | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>      |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis, MD 21401</b>  |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |  |   |   |  | Approximate Interval Between Onset and Death   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | a. <b>Carcinoma of unknown primary</b><br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | b. _____<br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | c. _____<br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | d. _____<br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  |  |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital:  |   | 26. Place of Death (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  | 29b. Signature and title of certifier<br>   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 29c. License number<br><b>DS2830</b>   |  |  |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 2012</b>   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeanne Werner, MD, 2023 Medical Parkway #210, Annapolis, MD 21401</b>   |  |  |   |   |  |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br> |   |   |  |  |  |  |   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15170

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-7 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

Jackie D. Schoolcraft

2. Date of Death

Month Day Year

MAY 03 2012

3. Time of Death

1:18 PM

4a. Facility Name (If not institution, give street and number)

Genesis Catan Manor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

274-30-2891

6. Sex

M

F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12/25/1934

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1  Yes  No

10e. Street and Number

6503 Baltimore Ave.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes  No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes  No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mary (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Margie Schoolcraft/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6503 Baltimore Ave., Dundalk, MD 21222

20a. Method of Disposition

1  Burial  Cremation 3  Removal from State4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

W. Arundel Crematory

Date

05/05/2012

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

► Margie Schoolcraft

M01452

22. Name and Address of Facility

Bailey Funeral Home and Cremation Service, PA  
4023 Annapolis Rd., Halethorpe, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Probable MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

FEW MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

b. Due to (or as a consequence of):

HYPERTENSION

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No9  Unknown

23c. If yes, outcome pf pregnancy

1  Live birth 2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown24a. Was an autopsy performed?  
1  Yes 2  No24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending investigation6  Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► MATEEN AWAJ

29c. License number

D0062634

29d. Date signed (Month, Day, Year)

MAY 03, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATEEN AWAJ 10796 HICKORY RIDGE RD COLUMBIA MD 21044

31. Date filed (Month, Day, Year)

MAY 11 2012

32. Registrar's Signature

Suzanne B. Parker

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15171

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|--|--|--|---|--|--|--|---|--|---|-------------------------------------|--|---------------------|--|-----------------------------------|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Brant Stine Sr.</b>   |   |  |  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> Year <b>2012</b>   |   | 3. Time of Death<br><b>12:34 PM</b> |  |                     |  |                                   |  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Mary's Hospital</b>   |   |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b> |  |   | 4c. County of Death<br><b>St. Mary's County</b>  |   |                                     |  |                     |  |                                   |  |  |
| Funeral Director   |  | 5. Social Security Number<br><b>189-16-6718</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b><br>Yrs.  | If Under 1 Year<br>Months                                  | If Under 24 Hrs.<br>Days                               | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 19, 1921</b>           | 9. Birthplace (State or Foreign Country)<br><b>Penna.</b>  |   |                                     |  |                     |  |                                   |  |  |
| To Be Completed by Funeral Director                                |  | Usual Residence of Decedent<br>10a. State <b>PA</b> 10b. County <b>Franklin</b> 10c. City, Town or Location <b>Greencastle</b>   |   |  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                     |  |                     |  |                                   |  |  |
|  |  | 10e. Street and Number<br><b>14260 Ridge Rd.</b>   |   |  | 10f. Zip Code<br><b>17225</b>                              |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |                                     |  |                     |  |                                   |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1949-52</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>  | 16b. Kind of Business Industry<br><b>Tool Co.</b>  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Columbus Christopher Stine</b>   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lulu Irene Forsythe</b>   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Beaver/Daughter</b>   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>999 Pensinger Rd. Greencastle, PA 17225</b>   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Gardens</b>  | Date<br><b>5/10/12</b>   |  |  | 20c. Location - City or Town, State<br><b>Chambersburg, PA</b>          |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  | 22. Name and Address of Facility<br><b>Zimmerman And Son Funeral Home Inc.<br/>45 S. Carlisle St. Greencastle, PA 17225</b>   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>YEARS</b>   |   |                                     |  |                     |  |                                   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | <p>a. Due to (or as a consequence of):<br/><b>MYOCARDIAL INFARCTION</b></p> <p>b. Due to (or as a consequence of):<br/><b>CORONARY ARTERY DISEASE</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>   |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |  |  |   |  | 23d. Date of delivery<br>Month Day Year |                                     |  |                     |  |                                   |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>  |   |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |                                     |  |                     |  |                                   |  |  |
|  |  |  |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                     |  |                                   |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 27. Manner of Death<br><table border="1"><tr><td><input checked="" type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending Investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Suicide</td><td></td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr></table>   | <input checked="" type="checkbox"/> Natural   | <input type="checkbox"/> Pending Investigation   | <input type="checkbox"/> Accident                          | <input type="checkbox"/> Could not be determined       | <input type="checkbox"/> Suicide  |  | <input type="checkbox"/> Homicide       |                                     | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |
| <input checked="" type="checkbox"/> Natural                        | <input type="checkbox"/> Pending Investigation   |  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
| <input type="checkbox"/> Accident                                  | <input type="checkbox"/> Could not be determined |  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
| <input type="checkbox"/> Suicide                                   |  |  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
| <input type="checkbox"/> Homicide                                  |  |  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  |  |   |  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                     |  |                     |  |                                   |  |  |
|  |  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 29b. Signature and title of certifier<br>  | 29c. License number<br><b>D64840</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/4/2012</b> |   |  |   |                                     |  |                     |  |                                   |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bruce Robert Gibson MD 25500 POINT LOOKOUT RD LEONARDTOWN MD 20650</b>  |   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  | 32. Registrar's Signature<br>   |  |  |  |   |  |   |                                     |  |                     |  |                                   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHARLES BRANDT STINE 5/4/2012 12:34 PM

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012

15172

## Certificate of Death

Reg. No.

1- For  
State  
RegisterPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial **B**

10+

Medical Certification; To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death   |
| <i>Thomas Thear</i>  |  | <i>April 23 2012</i>  |   | <i>2:20 pm M</i>   |
| 4a. Facility Name (If not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |
| <i>Potomac Valley Nursing Center</i>   |  | <i>Rockville</i>  |   | <i>Montgomery</i>  |
| 5. Social Security Number  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>83 Yrs.</i>  | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><i>12-08-1928 Pennsylvania</i>   |
| Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><i>Pennsylvania</i>   |   |  |
| 10a. State   | 10b. County  | 10c. City, Town or Location   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| <b>Maryland</b>  | <b>Montgomery</b>  | <b>Brookeville</b>  |   |  |
| 10e. Street and Number<br><b>20304 Lubar Way</b>   |  | 10f. Zip Code<br><b>20833</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1946-1948</b><br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Specify: White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br><b>Police Officer</b>   |   | 16b. Kind of Business/Industry<br><b>Montgomery County</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Adam Thear</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Smerkanich</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Chrysa M. Thear (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20304 Lubar Way, Brookeville, MD 20833</b>  |   |  |
| 20a. Method of Disposition<br><br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>St. John's Russian Orthodox Cemetery</i>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Apr. 28, 2012 Nesquehoning, PA</b>   |   | Date   |
| 21. Signature of Funeral Service Licensee<br><i>Tracy A. Sturges M. III, M.</i>  |  | 22. Name and Address of Facility DeVol Funeral Home<br><b>10 East Deer Park Drive Gaithersburg, MD 20877</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b>  |   |  |
| <p>a. Due to (or as a consequence of):<br/><b>Pneumonia</b></p> <p>b. Due to (or as a consequence of):<br/><b>Dementia</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <i>Unknown</i>                  |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |
| 25. Was case referred to medical examiner?<br><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury<br>M                  | 28c. Injury at Work?<br><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                   |  | 29b. Signature and title of certifier<br><i>A. Mendhiratta MD</i>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr A MENDHIRATTA 9043 Shady Grove Court Gaithersburg MD 20877</b>   |  | 29c. License number<br><b>D 33262</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 23 2012</b>  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br><i>Sandra S. Farak</i>   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15173

## Certificate of Death

Reg. No.

1- For State  
Registrar

|  |  |   |  |  |                          |   |   |
|--|--|---|--|--|--------------------------|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL DONNAVON TABOR, JR.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 2, 2012</b>   |                          |   | 3. Time of Death<br>1824 hrs                            |
| 4a. Facility Name (if not institution, give street and number)<br><b>Civista Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>LaPlata</b>   |                          |   | 4c. County of Death<br><b>Charles</b>                   |
| 5. Social Security Number<br><b>212-15-5847</b>  |  | 6. Sex<br><b>1 X M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>30 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days | 8. Date of Birth (MM/DD/YYYY)<br><b>OCT. 1, 1981</b>            | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
| Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>CHARLES</b> 10c. City, Town or Location<br><b>WHITE PLAINS</b>  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                          |   |   |
| 10e. Street and Number<br><b>9125 GENEVIEVE DRIVE</b>  |  |   |  | 10f. Zip Code<br><b>20695</b>  |                          |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>        |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <b>WHITE</b> |                          |   | 14. Race - American Indian, Black, White, etc.          |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELEVATOR MECHANIC</b>  |                          |   | 16b. Kind of Business/Industry<br><b>OTIS ELEVATORS</b> |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL D. TABOR SR.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHARON REGINA FERRIS</b>   |                          |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MICHAEL D. TABOR SR./SPOUSE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9125 GENEVIEVE DR., WHITE PLAINS, MD 20695</b>   |                          |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>Jon Taber</i> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HERITAGE CEMETERY</b>  |  | MAY Date<br><b>11, 2012</b>  |                          | 20c. Location - City or Town, State<br><b>WALDORF, MARYLAND</b> |   |
| 21. Signature of Funeral Service Licensee<br><i>Jon Taber</i> M00641   |  |   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNL. SERVICE, P.A.</b><br><b>5635 WASHINGTON AVE., LA PLATA, MD 20646</b>  |                          |   |   |

|  |  |  |  |   |  |                     |  |  |  |
|--|--|--|--|---|--|---------------------|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |  |  | a. <b>Complications of Chronic Alcohol Abuse</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____  |  |                     |  | Approximate Interval Between Onset and Death   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |                     |  | 23d. Date of delivery<br>Month Day Year  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |  |                     |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.  |  |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i>   |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  |                     |  | 29d. Date signed (Month, Day, Year)<br><b>May 3, 2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |  |  |   |  |                     |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><i>Sandra J. Parker</i> |  |   |  |                     |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15174

For  
State  
Registrar

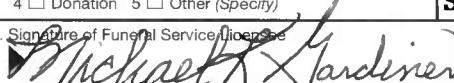
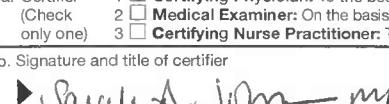
Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |   |   |   |  |
|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month April Day 30 Year 2012  |   | 3. Time of Death<br>1:45 A M   |
| <b>Ernest Conway Williams, Sr.</b>   |   |   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Hospice House of St. Mary's</b>   |   | 4b. City, Town, or Location of Death<br><b>Callaway</b>   |   | 4c. County of Death<br><b>St. Mary's</b>   |
| 5. Social Security Number<br><b>216-22-2837</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b><br>Yrs.   | If Under 1 Year<br>Months      Days      Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>02/07/1930</b>                          |
| Usual Residence of Decedent<br><b>Maryland</b>   |   | 10c. City, Town or Location<br><b>Clements</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                          |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>St. Mary's</b>  | 10f. Zip Code<br><b>20624</b>   |   | 10g. Citizen of What Country?<br><b>U S A</b>  |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) <b>12</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br><b>Owner/Operator</b>   | 16b. Kind of Business/Industry<br><br><b>Excavating Company</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph G. Williams, Sr.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jane Burroughs</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><br><b>Ernest C. Williams, Jr./Son</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br><b>P.O. Box 162, Clements, MD 20624</b>  |   |  |
| 20a. Method of Disposition<br><br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br><b>Sacred Heart Catholic</b>  | Date<br><b>05/03/2012</b>   | 20c. Location - City or Town, State<br><br><b>Bushwood, MD</b>                       |
| 21. Signature of Funeral Service Licensee<br><br>   |   | 22. Name and Address of Facility<br><br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>41590 Fenwick St., Leonardtown, MD 20650</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |
| <p>a. <u>Mantle cell lymphoma</u><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |   |  |
| Approximate Interval Between Onset and Death   |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |  |
|  |   | 23d. Date of delivery<br>Month Day Year   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |
| <p>23e. Did tobacco use contribute to the cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>   |   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br><br><b>Hospice House</b>   |   |  |
| Hospital:  |   | 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29b. Signature and title of certifier<br><br>   |   | 29c. License number<br><b>D71807</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>                         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sarah A. Johnson, MD 40900 Merchants Ln Ste 207 Leonardtown, MD 20650</b>   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 02 2012</b>  |   | 32. Registrar's Signature<br>  |   |  |

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State of Maryland / Department of Health and Mental Hygiene

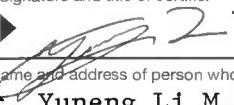
Certificate of Death

Reg. No.

2012 15175

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>XI WU</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> , 2012 Year  |  | 3. Time of Death<br>4:25 PM  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Suburban Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>220-15-8851</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months      Days  | If Under 24 Hrs.<br>Hours      Min.  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct.1, 1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>China</b>  |  | 10. Usual Residence of Decedent  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>10250 Westlake Drive</b>   |  | 10f. Zip Code<br><b>20817</b>  |  |
| 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>4</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Arch-Machinery Company</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Sijin Wu</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Junghua Wu</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Quan Lu (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1009 Welsh Drive, Rockville, MD 20852</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Gate of Heaven Cem.</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>  |  | Date<br><b>April 30, 2012</b>  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Curtis E Day (M01116)</b>   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b>   |  | 10 East Deer Park Dr. Gaithersburg, MD 20877   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | 23c. Approximate Interval Between Onset and Death  |  |
| a. Due to (or as a consequence of):<br><b>Stroke</b>  |  | b. Due to (or as a consequence of):   |  | c. Due to (or as a consequence of):  |  |
| d. Due to (or as a consequence of):   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D67986</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D67986</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Yuneng Li M.D. 8600 Old Georgetown Road, Bethesda, MD 20814</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br>   |  |

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

WU/XYI 100 4/23/2012 1025

Within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register AMEND#23a(b) per MD.5/7/12: FMW, MCo

## Certificate of Death

Reg. No.

2012 15176

|   |   |   |  |  |   |   |  |
|---|---|---|--|--|---|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Gloria S. Wiley</b>  |   |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>26</b> Year <b>12</b>   | 3. Time of Death<br><b>1755</b> M                                 |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>188-22-3088</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 27, 1927</b>   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                |
|   | Usual Residence of Decedent<br><b>Maryland Prince George's</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <b>To Be Completed by Funeral Director</b>  | 10e. Street and Number<br><b>3154 Gracefield Road, #320</b>   |   |  | 10f. Zip Code<br><b>20904</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>2</b>              |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify:                                     |
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>2</b><br><b>Homemaker</b> |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Schooley</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Iona</b>   |  |   |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Wiley - Spouse</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3154 Gracefield Rd., #320, Silver Spring, MD 20904</b>                 |  |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► Michael N. Verma MO1241</b> |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>   |  | Date<br><b>05/03/2012</b>   | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b> |  |
| 21. Signature of Funeral Service Licensee<br><b>Michael N. Verma MO1241</b>   |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.</b><br><b>11800 New Hampshire Ave., Silver Spring, MD 20904</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):  |   |   |  |  |   |   |  |
| b. <b>Suspected Ischemic Bowel</b><br>Due to (or as a consequence of):  |   |   |  |  |   |   |  |
| c. <b>Atrial Fibrillation</b><br>Due to (or as a consequence of):   |   |   |  |  |   |   |  |
| d.  |   |   |  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month Day Year                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)        |  |  |   |   |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural</b> <b>5 <input type="checkbox"/> Pending Investigation</b><br><b>2 <input type="checkbox"/> Accident</b> <b>6 <input type="checkbox"/> Could not be determined</b><br><b>3 <input type="checkbox"/> Suicide</b><br><b>4 <input type="checkbox"/> Homicide</b>  |   | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                                 |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2 <input type="checkbox"/> Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>► Eugenio S. Machado, M.D.</b>  |   | 29c. License number<br><b>D24035</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 27, 2012</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eugenio S. Machado, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904</b>  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |   | 32. Registrar's Signature<br><b>Eugenio S. Machado</b>  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit.

Division of Vital Records, P.O. Box 68760

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

2012 15177

## Certificate of Death

Reg. No.

1 - For State Registrar

|  |  |  |  |   |   |  |   |  |   |   |  |
|--|--|--|--|---|---|--|---|--|---|---|--|
| Physician/<br>Medical<br>Examiner                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>MALCOLM J. WASHINGTON</b>   |  |   |   |  |   | 2. Date of Death<br>Month <b>4</b> Day <b>24</b> Year <b>2012</b>  |   | 3. Time of Death<br><b>04:44 AM</b>   |  |
| Funeral<br>Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>1111 Cedarcliff Drive</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  |   | 4c. County of Death<br><b>Anne Arundel</b>   |   |   |  |
| To Be Completed by Funeral Director                                |  | 5. Social Security Number<br><b>213-41-8791</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>18</b><br>Yrs.   |  | If Under 1 Year<br>Months      Days   | If Under 24 Hrs<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 18, 1994</b>          |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
| To Be Completed by Physician/Medical Examiner                      |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Glen Burnie</b>  |   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>1111 Cedarcliff Drive</b>   |  |   |   | 10f. Zip Code<br><b>21060</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Student</b>  |  |   | 16b. Kind of Business/Industry<br><b>High School</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 17. Father's Name (First, Middle, Last)<br><b>David Norfleet</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gwendolyn Washington</b>   |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn Washington /Mother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1111 Cedarcliff Drive Glen Burnie, MD 21060</b> |  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, INC.</b>  |  |   | Date <b>April 30, 2012</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146</b>              |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LYMPHOMA</b>  |  |   |   |  |   | Approximate Interval Between Onset and Death   |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | a. Due to (or as a consequence of):<br><b>LYMPHOMA</b>   |  |   |   |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | b. Due to (or as a consequence of):  |  |   |   |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | c. Due to (or as a consequence of):  |  |   |   |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | d. Due to (or as a consequence of):  |  |   |   |  |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>WISKOTT ALDRICH SYNDROME</b>  |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner                      |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      | 28d. Describe how injury occurred  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D 14774</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>4-24-12</b>   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHAHID AZIZ M.D. 445 DEFENSE Hwy, ANNAPOLIS, MD 21401</b>   |  |   |   |  |   |  |   |   |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15178

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
**Frank Wojciechowski**2. Date of Death  
Month Day Year  
**April 22, 2012**3. Time of Death  
5:45 AMFuneral  
Director4a. Facility Name (if not institution, give street and number)  
**VA Maryland Health Care System**4b. City, Town, or Location of Death  
**Perry Point**4c. County of Death  
**Cecil**5. Social Security Number  
**218-30-5413**6. Sex  
**M**7. Age (in yrs. last birthday)  
**77**

Yrs.

If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
Month Day Year  
**03/21/1935**9. Birthplace (State or Foreign  
Country)  
**Maryland**

Usual Residence of Decedent

10a. State  
**MD**10b. County  
**Anne Arundel**10c. City, Town or Location  
**Glen Burnie**10d. Inside City Limits  
**Yes**10e. Street and Number  
**1705 Kirk Road**10f. Zip Code  
**21061**10g. Citizen of What Country?  
**USA**11. Marital Status  
**Never Married**12. Was Decedent Ever in U.S.  
Armed Forces?  
**Yes**13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
**No**14. Race - American Indian,  
Black, White, etc.  
**White**15. Decedent's Education  
(Specify only highest grade completed)  
**Elementary/Seconday (0-12)**16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
**Bookbinder**16b. Kind of Business Industry  
**Publishing**17. Father's Name (First, Middle, Last)  
**Frank Wojciechowski**18. Mother's Name (First, Middle, Maiden Surname)  
**Marjorie Cameron**19a. Informant's Name/Relationship (Type, Print)  
**Bernard Wojciechowski Brother**19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**1705 Kirk Road Glen Burnie, MD 21061**20a. Method of Disposition  
**Burial**20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
**Atlantic Crematory**Date  
**04/23/2012**20c. Location - City or Town, State  
**Glen Burnie, MD**21. Signature of Funeral Service Licensee  
**Dale J. O'Neil**22. Name and Address of Facility  
**851 Annapolis Road  
Hardesty Funeral Home P.A. Gambrills, MD 21054**Approximate  
Interval Between  
Onset and Death  
**Unknown**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)  
**Lower Gastrointestinal Bleed**a. Due to (or as a consequence of):  
**Lower Gastrointestinal Bleed**b. Due to (or as a consequence of):  
**Lower Gastrointestinal Bleed**c. Due to (or as a consequence of):  
**Lower Gastrointestinal Bleed**d. Due to (or as a consequence of):  
**Lower Gastrointestinal Bleed**IF FEMALE:  
23b. Was decedent pregnant  
in the past 12 months?  
**Yes**23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1  Yes 2  No 3  Probably 4  Unknown25. Was case referred to medical  
examiner?  
1  Yes 2  NoHospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)27. Manner of Death  
1  Natural 5  Pending  
2  Accident Investigation  
3  Suicide 6  Could not be  
determined28a. Date of injury  
(Month, Day, Year)  
**April 22, 2012**28b. Time of  
injury  
**M**28c. Injury at  
work?  
1  Yes 2  No

28d. Describe how injury occurred

29a. Certifier  
(Check  
only one)  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.29c. License number  
**PA state**29d. Date signed (Month, Day, Year)  
**April 22, 2012**30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**Deborah Bullock, M.D., VA Maryland Health Care System, Perry Point, MD 21902**31. Date filed (Month, Day, Year)  
**APR 26 2012**32. Registrar's Signature  
**Deborah J. Bullock**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15179

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                  |                  |
|--|----------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death                 | 3. Time of Death |
| <b>Paul Leo Wallace</b>                  | Month Day Year<br>April 25, 2012 | 0011 hrs         |

**Funeral Director**

|  |  |                                |                 |                  |                               |  |
|--|--|--------------------------------|-----------------|------------------|-------------------------------|--|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death                                 | 4c. County of Death            |                 |                  |                               |  |
| Southern Maryland Hospital                                     | Clinton  | Prince George's                |                 |                  |                               |  |
| 5. Social Security Number                                      | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign Country) |
| <b>579-02-2877</b>   | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | <b>49</b> Yrs.                 | Months          | Days             | Hours Min.                    | <b>April 5, 1963</b> Maryland            |

**To Be Completed by Funeral Director**

|                                |                       |                               |   |
|--------------------------------|-----------------------|-------------------------------|---|
| 10a. State                     | 10b. County           | 10c. City, Town or Location   | 10d. Inside City Limits   |
| <b>Maryland</b>                | <b>Prince Georges</b> | <b>Forestville</b>            | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number         | 10f. Zip Code         | 10g. Citizen of What Country? |   |
| <b>1844 Addison Road South</b> | <b>20747</b>          | <b>United States</b>          |   |

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:                             | Specify: <b>Black</b>                          |

|   |   |                                |
|---|---|--------------------------------|
| 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| Elementary/Secondary (0-12) <b>12th grade</b>                   | College (1-4 or 5+) <b>Roofer</b>   | <b>Construction</b>            |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)                           | 18. Mother's Name (First, Middle, Maiden Surname)   |
| <b>Wilton Wallace, Sr.</b>  | <b>Virginia Warner</b>  |
| 19a. Informant's Name/Relationship (Type, Print) <b>(Brother)</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| <b>Wilton Wardell Wallace</b>                                     | <b>1718 Quarter Avenue; Capitol Heights, Maryland 20743</b>                                   |

|   |  |                    |                                     |
|---|--|--------------------|-------------------------------------|
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date               | 20c. Location - City or Town, State |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | <b>Chesapeake Crematory, Inc.</b>                                      | <b>May 8, 2012</b> | <b>Beltsville, Maryland</b>         |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify  |  |                    |                                     |

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility   |
| <i>Donald B. Brown</i>                    | <b>R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011</b> |

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death         |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Alcohol and Narcotic (Heroin) Intoxication</b> |
|   | Due to (or as a consequence of):                     |

|  |                                  |
|--|----------------------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.                               |
|  | Due to (or as a consequence of): |
|  | c.                               |
|  | Due to (or as a consequence of): |
|  | d.                               |

|   |   |                       |
|---|---|-----------------------|
| <input checked="" type="checkbox"/> UNPENDED  | <input checked="" type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g927 5-14-12 sm<br>23a, pt. 11, per me, g928 6-25-12 sm | 23d. Date of delivery |
| IF FEMALE:  | 23c. If yes, outcome of pregnancy   | Month Day Year        |
| 23b. Was decedent pregnant in the past 12 months?   | 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy   |                       |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)                             |                       |
|   | 9 <input type="checkbox"/> Unknown  |                       |

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?   |
| <b>Chronic Alcoholism</b>  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?   |
|  | 24b. Were autopsy findings available prior to completion of cause of death?  |
|  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |

|   |   |                                     |
|---|---|-------------------------------------|
| 25. Was case referred to medical examiner?                              | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one) |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:                    |                                     |

|   |  |                     |   |                                   |
|---|--|---------------------|---|-----------------------------------|
| 27. Manner of Death   | 28a. Date of Injury (Month, Day, Year)                                       | 28b. Time of Injury | 28c. Injury at Work?  | 28d. Describe how injury occurred |
| 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation | <b>fd 4-24-12</b>  | <b>fd 11:05 pm</b>  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | <b>unknown</b>                    |
| 2 <input type="checkbox"/> Accident   |  |                     |   |                                   |
| 3 <input type="checkbox"/> Suicide  |  |                     |   |                                   |
| 4 <input type="checkbox"/> Homicide   |  |                     |   |                                   |
| 6 <input checked="" type="checkbox"/> Could not be determined                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. |                     |   |                                   |
|   | <b>Friend's House</b>  |                     |   |                                   |
|   |  |                     |   |                                   |

|  |                                       |                      |                                     |
|--|---------------------------------------|----------------------|-------------------------------------|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                               | 29b. Signature and title of certifier | 29c. License number  | 29d. Date signed (Month, Day, Year) |
| one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | <i>Theodore M. King, Jr., MD.</i>     | O.C.M.E. <i>OCME</i> | <b>April 25, 2012</b>               |

|  |                                   |                           |
|--|-----------------------------------|---------------------------|
| 30. Name and address of person who completed cause of death (Item 23a)                             | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
| Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | <b>MAY 08 2012</b>                | <i>Laura J. Parker</i>    |

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|   |  |
|---|--|
| 23e. Did tobacco use contribute to the cause of death?                  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?  | 24b. Were autopsy findings available prior to completion of cause of death?  |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |

|   |   |                                     |
|---|---|-------------------------------------|
| 25. Was case referred to medical examiner?                              | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one) |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:                    |                                     |

|   |  |                     |   |                                   |
|---|--|---------------------|---|-----------------------------------|
| 27. Manner of Death   | 28a. Date of Injury (Month, Day, Year)                                       | 28b. Time of Injury | 28c. Injury at Work?  | 28d. Describe how injury occurred |
| 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation | <b>fd 4-24-12</b>  | <b>fd 11:05 pm</b>  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | <b>unknown</b>                    |
| 2 <input type="checkbox"/> Accident   |  |                     |   |                                   |
| 3 <input type="checkbox"/> Suicide  |  |                     |   |                                   |
| 4 <input type="checkbox"/> Homicide   |  |                     |   |                                   |
| 6 <input checked="" type="checkbox"/> Could not be determined                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. |                     |   |                                   |
|   | <b>Friend's House</b>  |                     |   |                                   |
|   |  |                     |   |                                   |

|  |                                       |                      |                                     |
|--|---------------------------------------|----------------------|-------------------------------------|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                               | 29b. Signature and title of certifier | 29c. License number  | 29d. Date signed (Month, Day, Year) |
| one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | <i>Theodore M. King, Jr., MD.</i>     | O.C.M.E. <i>OCME</i> | <b>April 25, 2012</b>               |

|  |                                   |                           |
|--|-----------------------------------|---------------------------|
| 30. Name and address of person who completed cause of death (Item 23a)                             | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
| Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 | <b>MAY 08 2012</b>                | <i>Laura J. Parker</i>    |

**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15180

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Yaofen Zhang

2. Date of Death

Month April Day 26 Year 2012

3. Time of Death

5:20 pM

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

213-89-7699

6. Sex

1  M  F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07/25/1922

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Fulton

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

7702 Elmwood Road

10f. Zip Code

20759

10g. Citizen of What Country?

China

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Doctor

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Dirong Zhang

18. Mother's Name (First, Middle, Maiden Surname)

Yulan Sun

19a. Informant's Name/Relationship (Type, Print)

Yuanchao Zhang - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7702 Elmwood Road Fulton, MD 20759

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Ardent Crematory 05/05/2012

Hanover, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility Harry H. Witzke's Family FH Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2 YEARS

a. **METASTATIC DUODENAL ADENOCARCINOMA**

Due to (or as a consequence of):

b. \_\_\_\_\_ Due to (or as a consequence of):

c. \_\_\_\_\_ Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?  
1  Yes 2  No

26. Place of Death (Check only one)

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

HOSPICE

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



D64395

APRIL 26, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE DOBERMAN, MD 6334 CEDAR LANE COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

APR 30 2012

32. Registrar's Signature



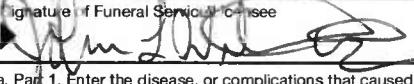
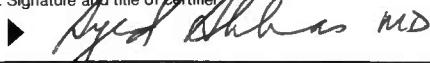
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15181

1- For  
State  
Registrar

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Ellsworth Atkins</b>  |  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> , 2012 Year | 3. Time of Death<br><b>0558 M</b>  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>                        |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-74-8986</b>  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>63 Yrs.</b>   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/13/1948</b>    | 9. Birthplace (State or Foreign<br>Country)<br><b>Maryland</b>             |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  | 10b. County<br><b>n/a</b>  | 10c. City, Town or Location<br><b>Baltimore</b>  | 10d. Inside City Limits<br><b>1 X Yes 2 F No</b>  |  |  |  |  |  |
|  | 10e. Street and Number<br><b>3516 West Forest Park Avenue</b>  |  |  | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                    |  |  |  |
|  | 11. Marital Status<br><b>1 X Never Married 2 F Married<br/>3 F Widowed 4 F Divorced</b>  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 F Yes 2 X No<br/>If Yes, Give Year or Dates.</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 F Yes 2 X No Specify: Black</b> |  |  | 14. Race - American Indian,<br>Black, White, etc.<br><b>Specify: Black</b> |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 0</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Disabled</b>                      |   | 16b. Kind of Business/Industry<br><b>n/a</b>                                 |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Calvin Whites Atkins</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mamie Marina Johnson</b>  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Price/ Sister</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4401 E. Rancier Ave #1801 Killeen, TX 76543</b>     |  |  |  |  |  |
|  | 20a. Method of Disposition<br><b>1 X Burial 2 F Cremation 3 F Removal from State<br/>4 F Donation 5 F Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |   | Date<br><b>5.14.2012</b>   | 20c. Location - City or Town, State<br><b>Gwynn Oak, MD</b>    |  |  |  |
|  | 21. Signature of Funeral Service to see<br>   |  | 22. Name and Address of Facility<br><b>John L. Williams Funeral Directors, P.A.<br/>4517 Park Heights Ave Baltimore, MD 21215</b>  |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Debility</b>  |  |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|  | a. Due to (or as a consequence of):<br><b>Debility</b>   |  |  |   |  |  |  |  |  |
|  | b. Due to (or as a consequence of):  |  |  |   |  |  |  |  |  |
|  | c. Due to (or as a consequence of):  |  |  |   |  |  |  |  |  |
|  | d. Due to (or as a consequence of):  |  |  |   |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 F Yes 2 F No 9 F Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 F Live Birth 2 F Fetal death 3 F Ectopic pregnancy<br/>4 F Pregnant at time of death 5 F Other (Specify)<br/>9 F Unknown</b>   |   |  |  | 23d. Date of delivery<br>Month Day Year                                    |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aspiration<br/>Dysphagia</b>  |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 F Yes 2 X No 3 F Probably 4 F Unknown</b> |  |
|  |  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><b>1 F Yes 2 X No</b>  |  |
|  |  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 F Yes 2 F No</b>     |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>1 F Yes 2 X No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 F Inpatient 2 F ER/Outpatient 3 F DOA</b> Other: <b>4 F Nursing Home 5 F Residence 6 X Other (Specify) Hospice</b> |   |  |  |  |  |  |
|  | 27. Manner of Death<br><b>1 X Natural 5 F Pending Investigation<br/>2 F Accident 6 F Could not be determined<br/>3 F Suicide<br/>4 F Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury   | 28c. Injury at work?<br><b>M 1 F Yes 2 F No</b>                              | 28d. Describe how injury occurred                              |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
|  | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>(Check only one)<br/>2 F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D72139</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>May 10<sup>th</sup> 2012</b>       |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  |  |   |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SYED Q. ABBAS MD 6701 N Charles Street Suite 4105 Baltimore MD 21204</b>  |  |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, 17, 18perFH, G927, 5/30/2012, WS

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No. 2012 15182

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show  
any injury or other traumatic event, the Medical Examiner must be notified at  
the time of death.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10V

|   |   |   |   |   |   |    |
|---|---|---|---|---|---|----|
| 1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death  |   | 3. Time of Death                                      |   |    |
| <i>Eleanor S. Bacon</i>   |   | Month   | Day   | Year  |   |    |
| 4a. Facility Name (If not institution, give street and number)  |   | 4b. City, Town, or Location of Death  |   | 4c. County of Death                                   |   |    |
| Lakeside at Mallard Landing   |   | Salisbury   |   | Wicomico  |   |    |
| 5. Social Security Number   | 6. Sex  | 7. Age (In yrs. last birthday)  | 8. Date of Birth (Month, Day, Year)   |   | 9. Birthplace (State or Foreign Country)  |    |
| 220-18-9033   | <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 89 Yrs.   | Months  | Days  | July 8, 1922  | MD |
| Usual Residence of Decedent   |   | 10d. Inside City Limits   |   |   |   |    |
| 10a. State  | 10b. County   | 10c. City, Town or Location   |   |   |   |    |
| MD  | Wicomico  | Salisbury   |   |   |   |    |
| 10e. Street and Number  |   | 10f. Zip Code   |   | 10g. Citizen of What Country?                         |   |    |
| 1109 S.<br>109 S. Schumaker Drive, Apt. 301   |   | 21804   |   | USA   |   |    |
| 11. Marital Status  | 12. Was Decedent Ever in U.S. Armed Forces?   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |   | 14. Race - American Indian, Black, White, etc.  |    |
| <input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give X<br>Year or Dates: |   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:                             |   | Specify: White  |    |
| 15. Decedent's Education<br>(Specify only highest grade completed)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |   | 16b. Kind of Business/Industry                        |   |    |
| Elementary/Secondary (0-12)   | College (1-4or 5+)  | 4 Librarian   |   | Education   |   |    |
| 17. Father's Name (First, Middle, Last)   |   | 18. Mother's Name (First, Middle, Maiden Surname)   |   |   |   |    |
| Harry Theophilus Stratten   |   | Secret Cyril Seacrist   |   |   |   |    |
| 19a. Informant's Name/Relationship (Type, Print)  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |   |   |   |    |
| Mr. Jeffrey S. Bacon (Son)  |   | 3777 Sand Road, Snow Hill, MD 21863   |   |   |   |    |
| 20a. Method of Disposition  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date  | 20c. Location - City or Town, State   |    |
| <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | All County Cremation  |   | 5/12/2012   | Sykesville, MD  |    |
| 21. Signature of Funeral Service Licensee   |   | 22. Name and Address of Facility  |   |   |   |    |
| <i>Brian Haight MOOT764</i>   |   | HAIGHT FUNERAL HOME & CHAPEL, PA<br>PO Box 195 Sykesville, MD 21784   |   |   |   |    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |   |   |    |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |   |   |   |    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |   |   |   |    |
| <p>a. Due to (or as a consequence of): <i>ASCV</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |   |   |   |   |   |    |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown                                   |   | 23d. Date of delivery<br>Month Day Year               |   |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   |    |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |   |   |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Assisted Living</i>                  |   |   |   |    |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury M                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |    |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                     |   |    |
| 29a. Certifier<br>(Check only one)  |   | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |    |
| 29d. Signature and title of certifier<br><i>NH</i>  |   | 29e. License number<br><i>047094</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>5/11/12</i> |   |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Vet NATE SAN 1415 S DIVISION Street SYKESVILLE MD 21784</i>  |   |   |   |   |   |    |
| 31. Date filed (Month, Day, Year) <i>MAY 14 2012</i>  |   | 32. Registrar's Signature<br><i>Eleanor S. Bacon</i>  |   |   |   |    |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15183

Reg. No.

1 - For  
State  
Registrar

|  |  |  |   |  |   |  |  |
|--|--|--|---|--|---|--|--|
| <b>Physician/<br/>Medical<br/>Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>Virginia M. Bielecki</b>  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>9</b> Year <b>2012</b>   | 3. Time of Death<br><b>3:10 PM</b>                                |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>1138 Valentine Creek Drive</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Crownsville</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>                                       |  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>205-16-6091</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months      Days      Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 12, 1927</b>    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                      |  |
| <b>To Be Completed by Funeral Director</b> | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Dundalk</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|  | 10e. Street and Number<br><b>1932 Eastfield Road</b>   |  |   | 10f. Zip Code<br><b>21222</b>  | 10g. Citizen of What Country?<br><b>United States</b>             |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S.:<br>Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give<br>Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Albert Placek</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Mazur</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael J. Bielecki (Son)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1505 Habersham Place Crownsville, MD 21032</b>   |   |  |  |
| <b>Physician/<br/>Medical<br/>Examiner</b> | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>St. Stanislaus Cem.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Stanislaus Cem.</b>  | Date<br><b>5/15/2012</b>   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Michael Neiser</b>   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   | Approximate Interval Between Onset and Death<br><b>METASTATIC Non-Small cell Lung Cancer 4 mos</b>   |   |  |  |
|  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |  |   |  |   |  |  |
|  | 23b. If female:<br>23c. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>daughter's Residence</b> |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number<br><b>D33551</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>                   |
|  | 29b. Signature and title of certifier<br><b>Michael Auerbach</b>   |  |   | 29c. License number<br><b>D33551</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>                   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Auerbach, 9110 Philadelphia Rd. #3rd, Baltimore, MD 21237</b>   |  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   |  | 32. Registrar's Signature<br><b>Deborah A. Parker</b>                        |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

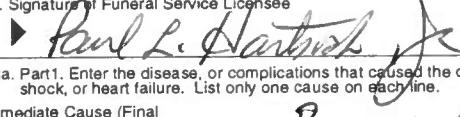
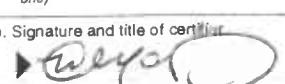
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15184

1- For  
State  
Registrar

|   |  |  |   |  |   |  |   |   |
|---|--|--|---|--|---|--|---|---|
| Physician /Medical Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Wesley Bowen</b>   |  |   |  |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>6</b> Year <b>2012</b>      | 3. Time of Death<br><b>8:35 P M</b>                           |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |   |  | 4c. County of Death<br><b>N/A</b>                                       |   |
| Funeral Director  | 5. Social Security Number<br><b>217-20-2940</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>87 Yrs.</b>  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 24, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |   |
| To Be Completed by Funeral Director                                 | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Catonsville</b> 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |   |
|   | 10e. Street and Number<br><b>603 Maiden Choice Lane</b>  |  |   | 10f. Zip Code<br><b>21228</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>5+</b> |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Roman Catholic Priest</b>  |  |   | 16b. Kind of Business/Industry<br><b>Church</b>                |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Wesley Bowen Jr</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Dolores Kircher</b>   |   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Fellow Priest<br/>Very Rev. Thomas R. Ulshafer-</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5408 Roland Avenue Baltimore, MD 21210</b> |   |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sulpician Cemetery</b>  |   |  | Date <b>May 15, 2012</b>  | 20c. Location - City or Town, State<br><b>Catonsville, MD</b> |
| Physician /Medical Examiner   | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility <b>Baltimore, Maryland 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>                             |   |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>RIGHT LOWER Lobe Pneumonitis</b> Due to (or as a consequence of): <b>3 days</b>   |  |   |  |   |  |   |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. RIGHT LOWER Lobe Pneumonitis</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>   |  |   |  |   |  |   |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   | 23d. Date of delivery<br>Month Day Year                        |   |   |
| Medical Certification To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe CORONARY HEART Disease</b><br><b>Ischemic CARDIOMYOPATHY, REFRACtORY</b><br><b>ATRIAL FIBRILLATION, HYPERTENSION</b>   |  |   |  |   |  |   |   |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |   |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |   |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |   |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |   |  |   |  |   |   |
|   | 28a. Date of Injury<br>(Month, Day Year)   |  | 28b. Time of Injury   |  | 28c. Injury at Work?  |  | 28d. Describe how injury occurred                                       |   |
|   |  |  |   |  | <b>M</b>  |  | <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>     |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  |   |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |   |
|   | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |   |
|   | 29b. Signature and title of certifier<br><br><b>ATTENDING PHYSICIAN</b>   |  |   |  |   |  |   |   |
|   | 29c. License number<br><b>D16200</b>   |  |   |  |   |  |   |   |
|   | 29d. Date signed (Month, Day, Year)<br><b>MAY 7, 2012</b>  |  |   |  |   |  |   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERTO M. MACHIRAN, M.D. 720 C MAIDEN CHOICE LANE, CATONSVILLE, MD 21228</b>   |  |   |  |   |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br>  |  |   |  |   |   |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

John W. Bowen

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15185

Reg. No.

1 For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month<br>May  |   | 3. Time of Death<br>Day<br>10<br>Year<br>2012<br>4:44 A M  |  |
| Richard Anthony Baclawski  |  |   |   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>4815 Arabia Avenue   |  | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death<br>N/A   |  |
| 5. Social Security Number<br>216-38-7595   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Months<br>If Under 24 Hrs.<br>Days Hours Min.   |  |
|  |  |   |   | 8. Date of Birth<br>(Month, Day, Year)<br>03-29-1938   | 9. Birthplace (State or Foreign Country)<br>Maryland   |
| Usual Residence of Decedent  |  | 10a. State<br>Maryland 10b. County<br>N/A 10c. City, Town or Location<br>Baltimore  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br>4815 Arabia Avenue   |  | 10f. Zip Code<br>21214  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>White |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Master Electrician  |   | 16b. Kind of Business Industry<br>Electrical Trade   |  |
| 17. Father's Name (First, Middle, Last)<br>John Baclawski  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances Janka  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Yvonne Baclawski - Wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4815 Arabia Avenue Baltimore, Maryland 21214   |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Stanislaus Cem.   |   | Date<br>05-12-2012   | 20c. Location - City or Town, State<br>Baltimore, Maryland                                     |
| 21. Signature of Funeral Service Licensee<br>► Charles Miner   |  | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><br>{<br>a. <u>Suspected Creutzfeld-Jakob disease</u><br>b. _____<br>c. _____<br>d. _____<br>Approximate Interval Between Onset and Death months   |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br>► Charles Miner   |  | 29c. License number<br>DS8303   |   | 29d. Date signed (Month, Day, Year)<br>MAY 11 2012   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Aaron J. Ettrich MD 6701 N. Charles St Towson MD   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br>►  |   |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15186

1 - For  
State  
Registrar

|  |  |   |   |   |  |   |   |   |   |  |
|--|--|---|---|---|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Dan King Burgess</b>  |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>May 12 2012 8:50 p M</b> | 3. Time of Death  |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Longview Nursing Home</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Manchester</b>   |  | 4c. County of Death<br><b>Carroll</b>                             |   |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-30-5779</b>  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.<br><b> </b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 30, 1932</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>       |   |   |   |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent<br>10a. State<br><b>Maryland</b> 10b. County<br><b>Carroll</b> 10c. City, Town or Location<br><b>Westminster</b>   |   |   |   |  |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |   |  |
|  | 10e. Street and Number<br><b>225 Frock Drive Apt. 225</b>  |   |   | 10f. Zip Code<br><b>21157</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                    |   |   |   |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                                   |   |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Self Employed</b>  |   | 16b. Kind of Business/Industry<br><b>Salesman</b>  |   |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Rob Roy Burgess</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth King</b>  |   |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rob Roy Burgess - son</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2236 Brown Rd. Finksburg, MD. 21048</b> |  |   |   |   |   |  |
|  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All Faiths Crematory</b>   |   | Date<br><b>May 15, 2012</b>  | 20c. Location - City or Town, State<br><b>Manchester, MD.</b>     |   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John DeWitt</b>  |   |   | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD. 21102</b>                              |  |   |   |   |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |   | Approximate Interval Between Onset and Death  |   |  |
|  | <p>a. Due to (or as a consequence of)<br/><b>Dysphagia</b><br/><b>Parkinsonism</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |   |   |   |  |   |   |   |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>              |   |  |   | 23d. Date of delivery<br>Month Day Year   |   |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aspiration pneumonia</b>  |   |   |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |  |
|  |  |   |   |   |  |   |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |
|  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   |  |   |   |   |   |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |   | 28a. Date of Injury<br>(Month, Day, Year)<br><b> </b>   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred                                 |   |   |   |  |
|  | 29a. Certifier<br>(Check only one)<br><b>2 <input type="checkbox"/> Medical Examiner</b>   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
|  | 29b. Signature and title of certifier<br><b>Magan Pansuriya, MD</b>  |   | 29c. License number<br><b>DO051705</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 14, 2012</b>        |   |   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Magan Pansuriya MD 349 Malcolm Dr. Westminster, MD 21157</b>  |   |   |   |  |   |   |   |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   | 32. Registrar's Signature<br><b>Anna J. Patel</b>   |   |  |   |   |   |   |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15187

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |  |  |  |   |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Iris June Brashears</b>  |  |  |  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 10, 2012</b>  | 3. Time of Death<br>8:30 AM  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>17 Cardinal Lane</b>   |  |  |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Essex</b>   | 4c. County of Death<br><b>Baltimore</b>  |   |  |  |
| 5. Social Security Number<br><b>213-28-4072</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><b>81 Yrs.</b> | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct 23, 1930</b>                    | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |   |  |  |
| Usual Residence of Decedent   |  | 10a. State<br><b>MD</b> 10b. County<br><b>Baltimore</b> 10c. City, Town or Location<br><b>Essex</b>  |  |  |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>17 Cardinal Lane</b>   |  |  |  | 10f. Zip Code<br><b>21221</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |  |  |   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Home Maker</b>  |  |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Owen Slough</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Flora E. Steuart</b>   |   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dawn Shepherd /Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 Cardinal Lane Essex, MD 21221</b> |   |  |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Chesapeake Crematory</b>  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>                                    |   |  | Date<br><b>May 11, 2012</b>  | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>                             |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Linda Dueitt M01443</b>   |  |  |  | 22. Name and Address of Facility<br><b>Cremation and Funeral Alternatives<br/>8717 Green Pastures Drive Towson Maryland 21286</b>        |   |  |  |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 year</b>  |  |   |  |  |
| <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p><b>{</b></p> <p>a. Due to (or as a consequence of):<br/><b>Alzheimer's dementia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |  |  |  |   |  |  |  |   |  |  |
| IF FEMALE:  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown    |  |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b>   |  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>JSL DO</b>  |  | 29c. License number<br><b>H35593</b>   |  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/2012</b>  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR John VLOH 1124 Mace Ave., Ba Hd, MD 21221</b>   |  |  |  |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br><b>Laura J. Park</b>  |  |  |   |  |  |  |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

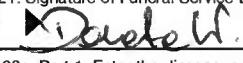
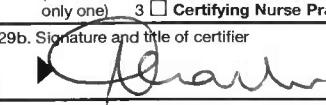
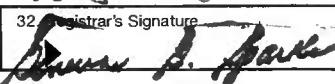
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15188

1 - For  
State  
Registrar

Reg. No.

|  |  |   |   |  |  |  |   |  |                             |
|--|--|---|---|--|--|--|---|--|-----------------------------|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Cary Baxter Beehler</b>   |   |   |  |  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>2012</b>   | 3. Time of Death<br>5:20 PM |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice Center</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>                        |  |  | 4c. County of Death<br><b>Baltimore</b>                     |  |                             |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-20-7719</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                             | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/>   | If Under 24 Hrs.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>               | 8. Date of Birth<br>(Month, Day, Year)<br><b>10/13/1920</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                             |
|  | Usual Residence of Decedent<br><b>MD Baltimore</b>   |   | 10c. City, Town or Location<br><b>Towson</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |                             |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   |   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Towson</b>                |  |                             |
|  | 10e. Street and Number<br><b>1055 West Joppa Road, Apt. 417</b>  |   |   |  | 10f. Zip Code<br><b>21204</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |                             |
| Physician/<br>Medical<br>Examiner  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:   |                             |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>12</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>        |  | 16b. Kind of Business/Industry<br><b>Homemaker</b>   |  |   | Own Home   |                             |
| 17. Father's Name (First, Middle, Last)<br><b>Wiley Baxter</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Fluharty</b>   |  |   |  |                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bruce M. Beehler / Son</b>  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6421 Broad Street, Bethesda, MD 20816</b>  |  |   |  |                             |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Marshall</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Date<br><b>5/9/2012</b>  | 20c. Location - City or Town, State<br><b>Beltsville, MD</b>                                   |   |  |                             |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203</b>   |  |  |  |   |  |                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Stroke</b>  |  |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>Days</b>  |                             |
| <p>a. Due to (or as a consequence of):<br/><b>Stroke</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |  |   |   |  |  |  |   |  |                             |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                   |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                             |
|  |  |   |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                             |
|  |  |   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                             |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |  |  |   |  |                             |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |   |  |                             |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |                             |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |   |  |                             |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D58303</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 8 2012</b>                                       |   |  |                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Aaron J Charles MD 6701 N. Charles St Towson MD</b>   |  |   |   |  |  |  |   |  |                             |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |   |  |                             |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15189

**Physician/  
Medical Examiner****1- For State  
Registrar**

1. Decedent's Name (First, Middle, Last)

Deborah Darlene Brown

Reg. No.

2. Date of Death  
Month Day Year  
May 9, 2012 1000 hrs**Funeral  
Director**

|   |  |  |   |   |                         |   |  |                     |  |
|---|--|--|---|---|-------------------------|---|--|---------------------|--|
| 4a. Facility Name (if not institution, give street and number)<br>633 North Aisquith Street |  |  |   | 4b. City, Town, or Location of Death<br>Baltimore |                         |   |  | 4c. County of Death |  |
| 5. Social Security Number<br>217-68-3490  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>53 Yrs. | If Under 1 Year<br>Months                         | If Under 24Hrs.<br>Days | 8. Date of Birth (MM/DD/YYYY)<br>07/18/1958 | 9. Birthplace (State or Foreign Country)<br>Maryland |                     |  |

|                  |  |                    |  |  |  |  |  |
|------------------|--|--------------------|--|--|--|--|--|
| 10a. State<br>MD |  | 10b. County<br>n/a | 10c. City, Town or Location<br>Baltimore |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|------------------|--|--------------------|--|--|--|--|--|

|  |  |  |                        |                                      |  |  |
|--|--|--|------------------------|--------------------------------------|--|--|
| 10e. Street and Number<br>633 North Aisquith Street Apt. 18J |  |  | 10f. Zip Code<br>21202 | 10g. Citizen of What Country?<br>USA |  |  |
|--|--|--|------------------------|--------------------------------------|--|--|

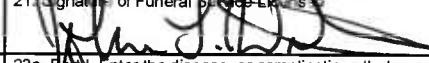
|  |  |   |  |
|--|--|---|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:<br>Specify: White | 14. Race - American Indian, Black, White, etc. |
|--|--|---|--|

|  |  |   |                                       |
|--|--|---|---------------------------------------|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>disabled | 16b. Kind of Business/Industry<br>n/a |
|--|--|---|---------------------------------------|

|   |  |   |  |  |
|---|--|---|--|--|
| 17. Father's Name (First, Middle, Last)<br>Letcher Boyd Brown |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Patsy Elizabeth Sexton |  |  |
|---|--|---|--|--|

|  |  |   |  |  |
|--|--|---|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Carpenter/ Daughter |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>584 West Court Glen Burnie, MD 21061 |  |  |
|--|--|---|--|--|

|   |   |                   |  |
|---|---|-------------------|--|
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>On-Site Crematory | Date<br>5.13.2012 | 20c. Location - City or Town, State<br>Baltimore, MD |
|---|---|-------------------|--|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br>John L. Williams Funeral Directors, P.A.<br>4517 Park Heights Ave Baltimore, MD 21215 |
|--|---|

**Baltimore, MD 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**To Be Completed by Funeral Director****Medical Certification: To Be Completed by Physician/Medical Examiner**

|  |  |  |  |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | a. <b>Methadone Intoxication</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
|  |  | b. _____<br>Due to (or as a consequence of): |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
|  |  | c. _____<br>Due to (or as a consequence of): |  |
|--|--|--|--|

|  |  |          |  |
|--|--|----------|--|
|  |  | d. _____ |  |
|--|--|----------|--|

|   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g927 5-23-12 sm | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|   |  |
|---|--|
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|---|--|

|  |   |  |
|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|--|

|   |   |                                     |
|---|---|-------------------------------------|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene | 26. Place of Death (Check only one) |
|---|---|-------------------------------------|

|  |   |                                   |   |  |
|--|---|-----------------------------------|---|--|
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>fd 5-9-12 | 28b. Time of Injury<br>fd 9:50 am | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>unknown |
|--|---|-----------------------------------|---|--|

|   |  |
|---|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Residence | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>633 N. Aisquith St. Baltimore, MD. |
|---|--|

|  |                                 |   |
|--|---------------------------------|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 10, 2012 |
|--|---------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|--|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012 | 32. Registrar's Signature<br> |
|--|--|

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15190

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month <u>05</u> Day <u>10</u> Year <u>2012</u>   |  | 3. Time of Death<br><u>10:30 PM</u>  |
| John F. Carroll  |  | 4b. City, Town, or Location of Death<br><u>Rosedale</u>  |  | 4c. County of Death<br><u>Baltimore</u>  |
| 4a. Facility Name (if not institution, give street and number)<br><u>FRANKLIN Square Hospital</u>  |  | 4b. City, Town, or Location of Death<br><u>Rosedale</u>  |  | 4c. County of Death<br><u>Baltimore</u>  |
| 5. Social Security Number<br><u>217-30-3342</u>  |  | 6. Sex<br><u>M</u>   | 7. Age (in yrs. last birthday)<br><u>77</u> Yrs.                                       | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><u>April, 29, 1935</u>  |
| 9. Birthplace (State or Foreign Country)<br><u>Pennsylvania</u>  |  | 10. Usual Residence of Decedent<br>10a. State <u>Maryland</u> 10b. County <u>Baltimore</u> 10c. City, Town or Location <u>Baltimore</u>  |  | 10d. Inside City Limits<br><u>Yes</u> 2 <u>No</u>  |
| 10e. Street and Number<br><u>5025 Wright Avenue</u>  |  | 10f. Zip Code<br><u>21205</u>  |  | 10g. Citizen of What Country?<br><u>United States</u>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) <u>8th</u>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <u>N/A</u><br>Sheet Metal Worker   |  | 16b. Kind of Business Industry<br><u>Manufacturing</u>   |
| 17. Father's Name (First, Middle, Last)<br><u>William Carroll</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Margaret Morris</u>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>June Carroll (Wife)</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5025 Wright Avenue Baltimore, MD 21205</u>   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Gardens of Faith</u>  |  | Date<br><u>5/15/12</u>   |
| 21. Signature of Funeral Service Licensed<br>  |  | 22. Name and Address of Facility<br><u>Duda-Ruck Funeral Home of Dundalk, Inc.</u><br><u>7922 Wise Ave. Dundalk, Maryland 21222</u>  |  | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><u>Sepsis</u>   |  | Approximate Interval Between Onset and Death<br><u>Days</u>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><u>Severe Gastritis</u>   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28d. Describe how injury occurred  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><u>D54736</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>05, 10, 2012</u>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>KAMLUN AYUENG MD</u>  |  | 31. Date filed (Month, Day, Year)<br><u>MAY 14 2012</u>  |  | 32. Registrar's Signature<br><u>James J. Farrel</u>  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Carroll John  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 1519

1- For State Registrar

## Certificate of Death

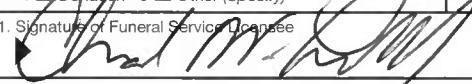
Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

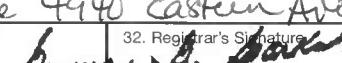
Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|   |  |   |  |  |   |  |   |  |
|---|--|---|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary S. Cuprik</b>   |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b>  |   | 3. Time of Death<br><b>8:15 P M</b>                            |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>6715 Woodley Road</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  |   | 4c. County of Death<br><b>Baltimore</b>                        |   |  |
| 5. Social Security Number<br><b>198-16-7975</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88 Yrs.</b>   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 4, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>         |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |   |  |   |  |
| 10e. Street and Number<br><b>6715 Woodley Road</b>  |  |   |  | 10f. Zip Code<br><b>21222</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br><b>Elementary/Secondary (0-12) 12th</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br><b>College (1-4 or 5+) N/A Clerk</b> |  |   | 16b. Kind of Business/Industry<br><b>Automotive</b>            |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Casimir Stelmack</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Gawnick</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>April Hughes (granddaughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5144 New Gerst Lane Perry Hall, MD 21128</b> |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp</b>  |  |   | Date<br><b>5/14/2012</b>                                       | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>          |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>                                |  |   |  |   |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |                     |   |  |  |   |
|--|--|--|---------------------|---|--|--|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <b>Pulmonary Edema</b><br><br><b>Congestive Heart Failure</b>  |                     |   |  | Approximate Interval Between Onset and Death   |   |
| <b>a.</b> Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of):<br><br>  |  |  |                     |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |                     |   |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                     |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |  |  |                     |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                     |   |  |  |   |
| 27. Manner of Death<br><b>1 Natural</b> <b>5 Pending Investigation</b><br><b>2 Accident</b> <b>6 Could not be determined</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury | 28c. Injury at work?<br>M<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                          |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)          |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                     |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0063449</b>   |                     |   | 29d. Date signed (Month, Day, Year)<br><b>May 11, 2012</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Heather Agee 4940 Eastern Avenue Baltimore, MD 21224</b>  |  |  |                     |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br>   |                     |   |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 17 per fb g927 5-29-12 yr

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15192

Physician/  
Medical  
Examiner

Funeral  
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To Be Completed by Funeral Director

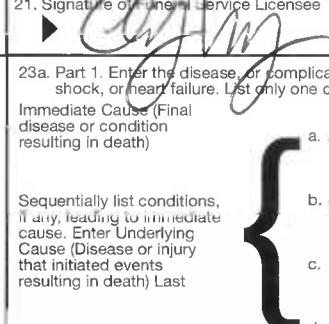
Baltimore, Maryland 21215-0036

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Physician/  
Medical  
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Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   | Margaret M. Devillier  |   |  | 2. Date of Death<br>Month Day Year<br>May 8, 2012  | 3. Time of Death<br>2030 P.M.  |  |
| 4a. Facility Name (if not institution, give street and number)   | The Johns Hopkins Hospital   |   |  | 4b. City, Town, or Location of Death<br>Baltimore City   | 4c. County of Death<br>N/A   |  |
| 5. Social Security Number<br>164-46-8425   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>60 Yrs.   | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>12-28-1951   | 9. Birthplace (State or Foreign Country)<br>PA                               |  |
| Usual Residence of Decedent  |  | 10a. State Maryland 10b. County Calvert 10c. City, Town or Location St. Leonard   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>1965 Matapeake Court   |  |   | 10f. Zip Code<br>20685   |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>White |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Teacher   | 16b. Kind of Business/Industry<br>Education  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Coneghell Coneghen  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hettie O'Donnell  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Moise DeVillier - Husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1965 Matapeake Court St. Leonard, Maryland 20685   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>Holy Sepulchre Cem.   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  | Date<br>5/18/2012  | 20c. Location - City or Town, State<br>Cheltenham, PA  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc.   | 5305 Harford Road Baltimore, Maryland 21214  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |  |
| <p>a. <u>Pneumonia</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Acute Myelogenous Leukemia</u><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  |  |  |  |
|  |  | 29c. License number<br>RES-000  |  |  | 29d. Date signed (Month, Day, Year)<br>May 8, 2012                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sudip Saha 406 North Wolfe Street, Baltimore MD 21287  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br>  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15193

1- For  
State  
Registrar

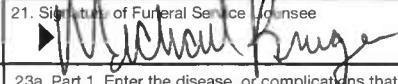
Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |             |   |  |  |  |                                   |  |   |    |
|---|-------------|---|--|--|--|-----------------------------------|--|---|----|
| 1. Decedent's Name (First, Middle, Last)  |             | 2. Date of Death  |  |  |  | 3. Time of Death                  |  |   |    |
| DOROTHY FORMAN  |             | Month   | Day  | Year   | May 10 2012  |                                   | 1:48 AM  |   |    |
| 4a. Facility Name (if not institution, give street and number)  |             | 4b. City, Town, or Location of Death  |  |  |  | 4c. County of Death               |  |   |    |
| Sinai Hospital of Baltimore   |             | Baltimore   |  |  |  | N/A                               |  |   |    |
| 5. Social Security Number   |             | 6. Sex  | 7. Age (in yrs. last birthday)   | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birth                  | 9. Birthplace (State or Foreign Country)       |   |    |
| 056-20-7035   |             | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                      | 84 Yrs.  | Months   | Days   | Hours                             | Min.   | 09/16/1927  | NY |
| Usual Residence of Decedent   |             |   |  |  |  |                                   |  |   |    |
| 10a. State  | 10b. County | 10c. City, Town or Location   |  |  |  |                                   |  | 10d. Inside City Limits   |    |
| MD  | N/A         | BALTIMORE   |  |  |  |                                   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |    |
| 10e. Street and Number  |             |   | 10f. Zip Code  |  |  | 10g. Citizen of What Country?     |  |   |    |
| 3211 CLARKS LANE, #420  |             |   | 21215  |  |  | USA                               |  |   |    |
| 11. Marital Status  |             | 12. Was Decedent Ever in U.S. Armed Forces?   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |                                   | 14. Race - American Indian, Black, White, etc. |   |    |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |             | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.    |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |                                   | Specify: WHITE                                 |   |    |
| 15. Decedent's Education (Specify only highest grade completed)   |             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  | 16b. Kind of Business Industry   |  |                                   |  |   |    |
| Elementary/Secondary (0-12) 12  |             | College (1-4 or 5+) CLERK   |  | NEW YORK PUBLIC SCHOOL SYSTEM  |  |                                   |  |   |    |
| 17. Father's Name (First, Middle, Last)   |             |   |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |                                   |  |   |    |
| HARRY AMSTER  |             |   |  | LILY COHEN   |  |                                   |  |   |    |
| 19a. Informant's Name/Relationship (Type, Print)  |             |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)                |  |                                   |  |   |    |
| BARRY GLOVITCH/SON  |             |   |  | 5 HARNESS COURT, #203, BALTIMORE, MD 21208   |  |                                   |  |   |    |
| 20a. Method of Disposition  |             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place) |  |  | Date                              | 20c. Location - City or Town, State            |   |    |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |             |   | BALTIMORE HEBREW CEM   |  |  | 05/11/2012                        | REISTERSTOWN, MD                               |   |    |
| 21. Signature of Funeral Service Licensee   |             |   |  | 22. Name and Address of Facility   |  |                                   |  |   |    |
|    |             |   |  | SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKEVILLE, MD 21208                                    |  |                                   |  |   |    |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |             |   |  |  |  |                                   |  |   |    |
| Immediate Cause (Final disease or condition resulting in death)   |             |   |  |  |  |                                   |  |   |    |
| Myocardial infarction   |             |   |  |  |  |                                   |  |   |    |
| Approximate Interval Between Onset and Death  |             |   |  |  |  |                                   |  |   |    |
| 10 years  |             |   |  |  |  |                                   |  |   |    |
| 23b. If yes, outcome of pregnancy   |             |   |  |  |  |                                   |  |   |    |
| 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |             |   |  |  |  |                                   |  |   |    |
| 23d. Date of delivery   |             |   |  |  |  |                                   |  |   |    |
| Month Day Year  |             |   |  |  |  |                                   |  |   |    |
| 23e. Did tobacco use contribute to the cause of death?  |             |   |  |  |  |                                   |  |   |    |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |             |   |  |  |  |                                   |  |   |    |
| 24a. Was an autopsy performed?  |             |   |  |  |  |                                   |  |   |    |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |             |   |  |  |  |                                   |  |   |    |
| 24b. Were autopsy findings available prior to completion of cause of death?   |             |   |  |  |  |                                   |  |   |    |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |             |   |  |  |  |                                   |  |   |    |
| 25. Was case referred to medical examiner?  |             |   |  |  |  |                                   |  |   |    |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |             |   |  |  |  |                                   |  |   |    |
| 26. Place of Death (Check only one)   |             |   |  |  |  |                                   |  |   |    |
| Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |             |   |  |  |  |                                   |  |   |    |
| 27. Manner of Death   |             |   |  |  |  |                                   |  |   |    |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |             | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury  | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |  |   |    |
| 3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                    |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                 |  |                                   |  |   |    |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             |   |  |  |  |                                   |  |   |    |
| 29b. Signature and title of certifier   |             |   |  |  |  |                                   |  |   |    |
| 29c. License number   |             |   |  |  |  |                                   |  |   |    |
| 29d. Date signed (Month, Day, Year)   |             |   |  |  |  |                                   |  |   |    |
| May 10, 2012  |             |   |  |  |  |                                   |  |   |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |             |   |  |  |  |                                   |  |   |    |
| Chad J. Hansen, M.D. 2401 W Belvedere Baltimore MD 21215  |             |   |  |  |  |                                   |  |   |    |
| 31. Date filed (Month, Day, Year)   |             |   |  |  |  |                                   |  |   |    |
| MAY 14 2012   |             |   |  |  |  |                                   |  |   |    |
| 32. Registrar's Signature   |             |   |  |  |  |                                   |  |   |    |
|    |             |   |  |  |  |                                   |  |   |    |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Patient known as: Dorothy  
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15191

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

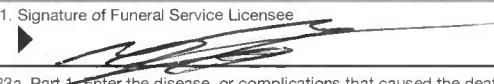
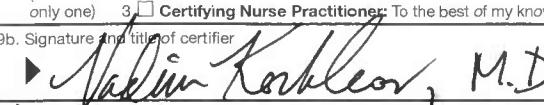
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit envelope.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |   |                          |  |   |
|--|--|---|--------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |                          | 3. Time of Death<br>3:25 P M   |   |
| <b>Edwin J. Gakenheimer</b>  |  | May 4 2012  |                          |  |   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |                          | 4c. County of Death  |   |
| <b>Baltimore Washington Medical Center Glen Burnie</b>   |  |   |                          | <b>Anne Arundel</b>  |   |
| 5. Social Security Number<br><b>215-14-0633</b>  |  | 6. Sex<br><b>1 X M 2 F</b>  |                          | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b>   |   |
|  |  |   |                          | If Under 1 Year<br>Months Days Hours Min.  |   |
|  |  |   |                          | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/23/23</b>   |   |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |                          |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |                          | 10c. City, Town or Location<br><b>Severn</b>   |   |
|  |  |   |                          | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>   |   |
| 10e. Street and Number<br><b>8130 Windmill Ct.</b>   |  | 10f. Zip Code<br><b>21144</b>   |                          | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 □ Never Married 2 X □ Married<br>3 □ Widowed 4 □ Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 X □ Yes 2 □ No<br>If Yes, Give Year or Dates.<br><b>WW II</b>  |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X □ No Specify:<br><b>White</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>                            |                          | 16b. Kind of Business/Industry<br><b>General Motors</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Anton Gakenheimer</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Anne Hackman</b>   |                          |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna C. Gakenheimer (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8130 Windmill Ct., Severn, MD 21144</b>                   |                          |  |   |
| 20a. Method of Disposition<br>1 X □ Burial 2 □ Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |                          | Date<br><b>5/8/12</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home<br/>3620 Wilkens Ave., Baltimore, MD 21229</b>  |                          |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><b>Bronchogenic carcinoma</b>  |                          | Approximate Interval Between Onset and Death<br><b>1 month</b>   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):   |                          |  |   |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 X □ Yes 2 □ No 3 □ Probably 4 □ Unknown   |                          |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No 9 □ Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |                          | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 X □ Yes 2 □ No 3 □ Probably 4 □ Unknown   |                          | 23e. Did tobacco use contribute to the cause of death?<br>1 X □ Yes 2 □ No 3 □ Probably 4 □ Unknown  |   |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X □ No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 X □ Inpatient 2 □ ER/Outpatient 3 □ DDA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)          |                          | 23e. Did tobacco use contribute to the cause of death?<br>1 X □ Yes 2 □ No 3 □ Probably 4 □ Unknown  |   |
| 27. Manner of Death<br>1 X □ Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 □ Yes 2 □ No   | 28d. Describe how injury occurred                                 |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 28a. Certifier<br>(Check only one)<br>1 X □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D68240</b>  |                          | 29d. Date signed (Month, Day, Year)<br><b>May 4, 2012</b>  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D68240</b>  |                          | 29d. Date signed (Month, Day, Year)<br><b>May 4, 2012</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vadim Korkhov 301 Hospital Drive, Glen Burnie, MD 21061</b>   |  | 32. Registrar's Signature<br>  |                          |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  |   |                          |  |   |

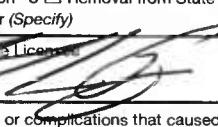
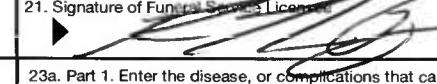
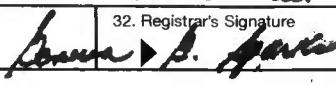
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15195

1- For  
State  
Registrar

|  |   |                                 |   |  |   |  |   |  |  |   |
|--|---|---------------------------------|---|--|---|--|---|--|--|---|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Irma Louise Glass</b>  |                                 |   |  |   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>9</b> Year <b>2012</b>                             | 3. Time of Death<br><b>2:15 AM</b>   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Center</b>   |                                 |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b> |  |   | 4c. County of Death<br><b>Baltimore</b>  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-12-4908</b>   |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   | If Under 1 Year<br>Months                             | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 6 1921</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |
| To Be Completed by Funeral Director                                | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Windsor Mill</b>  |  |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
|  | 10e. Street and Number<br><b>3410 Rockdale Court</b>  |                                 |   |  | 10f. Zip Code<br><b>21244</b>                         |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |                                 |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>           |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Pickett</b>  |                                 |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Yohn</b>   |   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Moore / Daughter</b>   |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1000 Amaranth Drive, Aurora, Illinois 60504</b>  |   |  |   |  |  |   |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)    |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HilltopServiceCorp.</b>   |   |  | Date<br><b>5/14/2012</b>                                    | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>                                 |  |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Director Licensed<br>   |                                 |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>  |   |  |   |  |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                 |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                                 |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown          |   |  | 23d. Date of delivery<br>Month Day Year                     |  |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Agitation</b><br><b>Dysphagia</b>  |                                 |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |   |                                 |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |   |  |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |                                 | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M                              | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                           |  |  |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 |   |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|  | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Only one<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                                 | 29c. License number<br><b>D72139</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>May 9/12 2012</b>  |   |  |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SYED Q. ABBAS 6701 N Charles Street Suite 4105 Baltimore MD 21204</b>  |                                 |   |  |   |  |   |  |  |   |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |                                 | 32. Registrar's Signature<br>                                  |  |   |  |   |  |  |   |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
 amend 16a, per fh, g927 5-14-12 sm  
 State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

**Certificate of Death**

Reg. No.

2012 15196

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

|  |  |  |  |  |   |   |
|--|--|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>CRAIG HARRIS</b>  |  |  |  | 2. Date of Death<br>Month <b>05</b> Day <b>07</b> Year <b>2012</b>   | 3. Time of Death<br><b>12:00 PM</b>   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>FUTURE CARE HOMEWOOD</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   |   |
| 4c. County of Death  |  |  |  |  |   |   |
| 5. Social Security Number<br><b>213-62-2256</b>  |  | 6. Sex<br><b>1 X M 2 <input type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. | If Under 1 Year<br>Months <b> </b> Days <b> </b> Hours <b> </b> Min. <b> </b>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-11-1954</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
| 10a. State<br><b>MD</b>  |  | 10b. County  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><b><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</b> |
| 10e. Street and Number<br><b>614 N. Castle Street</b>  |  |  |  | 10f. Zip Code<br><b>21205</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 X Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 X No<br/>If Yes, Give Year or Dates.</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: X</b> |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>                               |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Environmental Environmental Services</b>  |  | 16b. Kind of Business/Industry<br><b>Hospitality</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Herbert Jessie Harris</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Towns</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wife<br/>Beatrice Harris</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>614 N. Castle Street Balto MD 21205</b>  |   |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ardent Crem</b>   |  | Date<br><b>5-21-2012</b>   | 20c. Location - City or Town, State<br><b>Hanover, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Bruce Neelkay</b>  |  | 22. Name and Address of Facility<br><b>Phillip A Weatherford FS PA<br/>2431 E Oliver Street Balto, MD 21213</b>  |  |  |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>MULTIPLE STROKES</b><br><b>TTP</b><br><b>Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last</b><br><b>{</b><br><b>a. Due to (or as a consequence of):</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b> |  |  | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MCA STROKE</b>  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 X No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 X No</b>   |  | 26. Place of Death (Check only one)<br><b>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 X Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>                                     |  |  |   |   |
| 27. Manner of Death<br><b>1 X Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury                              | 28c. Injury at work?<br><b>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred   |   |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |  |  |  |   |   |
| 29b. Signature and title of certifier<br><b>Bhawneet Kaur MD</b>   |  | 29c. License number<br><b>735 75</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>05/14/2012</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bhawneet K. Bhawaj 8813 Waltham Woods Rd. Parkville MD-21234</b>  |  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br><b>Suzanne J. Parker</b>  |  |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15197

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|   |  |   |  |   |  |   |                           |   |      |   |  |  |  |
|---|--|---|--|---|--|---|---------------------------|---|------|---|--|--|--|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Betty Mae Hursey</b>   |  |   |  |   |                           | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>                                   |      | 3. Time of Death<br><b>1:39 AM</b>                                      |  |  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospital Center</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Westminster</b> |   |                           | 4c. County of Death<br><b>Carroll</b>   |      |   |  |  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>335-24-2332</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81 yrs.</b> Yrs.      |   | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Hours   | Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>05/09/1931</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |  |
| To Be Completed by Funeral Director           |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Finksburg</b>   |                           |   |      |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director           |  | 10e. Street and Number<br><b>1904 Andrea Court</b>  |  |   |  | 10f. Zip Code<br><b>21048</b>   |                           |   |      | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                           |   |      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b><br><b>3Yrs.</b>  |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Resident Nurse</b>   |                           |   |      | 16b. Kind of Business/Industry<br><b>Nursing</b>                        |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>William Henry Lange</b>   |  |   |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevieve King</b>                            |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Hursey (Son)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1904 Andrea Ct. Finksburg, Md. 21048.</b>   |                           |   |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>   |  | Date<br><b>05/15/2012</b>   |                           | 20c. Location - City or Town, State<br><b>Sykesville, Md.</b>   |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville, Md. 21784.</b>   |                           |   |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |   |                           |   |      |   |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |
| To Be Completed by Physician/Medical Examiner |  | <p>a. <b>Sepsis</b><br/>Due to (or as a consequence of):</p> <p>b. <b>colitis</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |   |  |   |                           |   |      |   |  | <b>4 days</b>  |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |   |                           | 23d. Date of delivery<br>Month Day Year   |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b>   |  |   |  |   |                           |   |      |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |      |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |                           | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |      | 28d. Describe how injury occurred                                       |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |                           |   |      |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0047979</b>  |  |   |                           | 29d. Date signed (Month, Day, Year)<br><b>05/13/12</b>  |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theresa M Michele 200 Memorial Ave. Westminster, MD 21157</b>  |  |   |  |   |                           |   |      |   |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br>  |  |   |                           |   |      |   |  |  |  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15198

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10V

|  |  |   |   |  |   |                 |                                     |   |   |    |
|--|--|---|---|--|---|-----------------|-------------------------------------|---|---|----|
|  |  | 1. Decedent's Name (First, Middle, Last)  |   |  | 2. Date of Death  |                 | 3. Time of Death                    |   |   |    |
|  |  | Fannie G. Henson  |   |  | Month   | Day             | Year                                |   |   |    |
|  |  | 4a. Facility Name (if not institution, give street and number)  |   |  | 4b. City, Town, or Location of Death  |                 | 4c. County of Death                 |   |   |    |
|  |  | 4420 Greencove Circle   |   |  | Edgemere  |                 | Baltimore                           |   |   |    |
|  |  | 5. Social Security Number   | 6. Sex  | 7. Age (In yrs. last birthday)   | If Under 1 Year   | If Under 24 Hrs | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country)  |   |    |
|  |  | 237-40-4838   | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F    | 79 Yrs.  | Months  | Days            | Hours                               | Min.  | Aug. 10, 1932   | NC |
|  |  | Usual Residence of Decedent   |   |  |   |                 |                                     |   |   |    |
|  |  | 10a. State  | 10b. County   | 10c. City, Town or Location  |   |                 |                                     |   | 10d. Inside City Limits   |    |
|  |  | MD  | Baltimore   | Edgemere   |   |                 |                                     |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |    |
|  |  | 10e. Street and Number  |   |  | 10f. Zip Code   |                 | 10g. Citizen of What Country?       |   |   |    |
|  |  | 4420 Green Cove Circle  |   |  | 21219   |                 | United States                       |   |   |    |
|  |  | 11. Marital Status  | 12. Was Decedent Ever in U.S. Armed Forces?                             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                 |                                     | 14. Race - American Indian, Black, White, etc.  |   |    |
|  |  | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | If Yes, Give Year or Dates.  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                     | Specify:        |                                     | Specify: White  |   |    |
|  |  | 15. Decedent's Education (Specify only highest grade completed)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |   |                 | 16b. Kind of Business/Industry      |   |   |    |
|  |  | Elementary/Secondary (0-12) 11 Years  |   | College (1-4 or 5+) Bus Driver   |   |                 | Baltimore County                    |   |   |    |
|  |  | 17. Father's Name (First, Middle, Last)   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                 |                                     |   |   |    |
|  |  | Horace Galloway   |   |  | Mae Middleton   |                 |                                     |   |   |    |
|  |  | 19a. Informant's Name/Relationship (Type, Print)  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)               |                 |                                     |   |   |    |
|  |  | Mrs. June Alley (Daughter)  |   |  | 4420 Green Cove Circle Edgemere, Maryland 21219   |                 |                                     |   |   |    |
|  |  | 20a. Method of Disposition  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |   | Date            | 20c. Location - City or Town, State |   |   |    |
|  |  | 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify Entombment)   |   | Oak Lawn Cemetery  |   | 5/12/2012       | Baltimore, Maryland                 |   |   |    |
|  |  | 21. Signature of Funeral Service Licensee   |   | 22. Name and Address of Facility   |   |                 |                                     |   |   |    |
|  |  | Gregory E. Reed   |   | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222   |   |                 |                                     |   |   |    |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |                 |                                     | Approximate Interval Between Onset and Death  |   |    |
|  |  | Immediate Cause (Final disease or condition resulting in death)   |   |  |   |                 |                                     |   |   |    |
|  |  | Respiratory arrest  |   |  |   |                 |                                     |   |   |    |
|  |  | Pulmonary fibrosis  |   |  |   |                 |                                     |   |   |    |
|  |  | b. Due to (or as a consequence of):   |   |  |   |                 |                                     |   |   |    |
|  |  | c. Due to (or as a consequence of):   |   |  |   |                 |                                     |   |   |    |
|  |  | d. Due to (or as a consequence of):   |   |  |   |                 |                                     |   |   |    |
|  |  | IF FEMALE:  |   | 23c. If yes, outcome of pregnancy  |   |                 |                                     | 23d. Date of delivery   |   |    |
|  |  | 23b. Was decedent pregnant in the past 12 months?   |   | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown |   |                 |                                     |   | Month Day Year  |    |
|  |  | 24. Did tobacco use contribute to the cause of death?   |   |  |   |                 |                                     |   |   |    |
|  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |                 |                                     |   |   |    |
|  |  | 24a. Was an autopsy performed?  |   |  |   |                 |                                     | 24b. Were autopsy findings available prior to completion of cause of death?   |   |    |
|  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Yes 4 <input checked="" type="checkbox"/> No   |   |  |   |                 |                                     |   |   |    |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |                 |                                     | 25. Was case referred to medical examiner?  |   |    |
|  |  | Parkinsonism  |   |  |   |                 |                                     | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |    |
|  |  | Anemia  |   |  |   |                 |                                     | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                    |   |    |
|  |  | CHF   |   |  |   |                 |                                     | Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |    |
|  |  | 26. Place of Death (Check only one)   |   |  |   |                 |                                     | 27. Manner of Death   |   |    |
|  |  | 27a. Date of injury (Month, Day, Year)  |   |  |   |                 |                                     | 28a. Time of injury   |   |    |
|  |  | 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |   |  |   |                 |                                     | M   |   |    |
|  |  | 28b. Injury at work?  |   |  |   |                 |                                     | 28c. Describe how injury occurred   |   |    |
|  |  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |                 |                                     | 28d. Location (Street and Number or Rural Route Number, City or Town, State)  |   |    |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |                 |                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |    |
|  |  | 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                 |                                     | 29b. Signature and title of certifier   |   |    |
|  |  | 29c. License number   |   |  |   |                 |                                     | 29d. Date signed (Month, Day, Year)   |   |    |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |   |  |   |                 |                                     | 31. Date filed (Month, Day, Year)   |   |    |
|  |  | 32. Registrar's Signature   |   |  |   |                 |                                     | NAY 14 2012   |   |    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

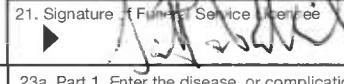
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15199

1 - For  
State  
Registrar

|  |   |  |  |   |  |  |  |  |  |  |  |
|--|---|--|--|---|--|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Arys Henry Huizinga</b>  |  |  |   |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>8</b> Year <b>2012</b>             |  | 3. Time of Death<br><b>9:58 AM</b>         |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>  |  |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>                     |  | 4c. County of Death<br><b>Anne Arundel</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>350-16-1017</b>   |  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct. 19, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>                    |  |  |  |
|  | Usual Residence of Decedent   |  |  |   | Days   | Min.   |  |  |  |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>                               |  |  |  |
|  | 10e. Street and Number<br><b>904 Shamrock Court</b>   |  |  |   | 10f. Zip Code<br><b>21060</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>                          |  |  |  |
|  | 11. Marital Status<br><b>1 □ Never Married 2 X Married</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No</b><br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No</b> Specify:                                  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>        |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>6</b><br><b>Maritime Engineer</b> |  |  | 16b. Kind of Business/Industry<br><b>Government</b>                            |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Arys Huizinga</b>   |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Smith</b>                                 |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Germaine Katherine Huizinga</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>904 Shamrock Court, Glen Burnie, Maryland 21060</b>                            |   |  | Date   |  | 20c. Location - City or Town, State<br><b>05/12/2012 Glen Burnie, MD 21061</b> |  |  |  |
|  | 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State</b><br><b>4 □ Donation 5 □ Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>  |   |  | 20c. Location - City or Town, State<br><b>05/12/2012 Glen Burnie, MD 21061</b>                           |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Kirkley-Ruddick Funeral Home</b><br><b>421 Crain Highway SE, Glen Burnie, MD 21061</b>  |   |  |  |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><b>SEPSIS</b>   |   |  | Approximate Interval Between Onset and Death   |  |  |  |  |  |
|  | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><b>FARM CAVALIC ARTERY</b>  |   |  |  |  |  |  |  |  |
|  |   |  | 23d. Due to (or as a consequence of):<br><b>ASPIRATION PNEUMONIA</b>   |   |  |  |  |  |  |  |  |
|  | 23e. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No 9 □ Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy</b><br><b>4 □ Pregnant at time of death 5 □ Other (specify)</b><br><b>9 □ Unknown</b> |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown</b>  |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>   |   |  |  |  |  |  |  |  |
|  | 24a. Was case referred to medical examiner?<br><b>1 □ Yes 2 □ No</b>  |  | 24b. Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>   |   |  | 24c. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown</b> |  |  |  |  |  |
|  | 25. Manner of Death<br><b>1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide</b>   |  | 26. Date of injury (Month, Day, Year)<br><b>28a. 1 □ Pending Investigation 6 □ Could not be determined</b>   |   |  | 26. Time of injury<br><b>28b. M</b>  |  | 26. Injury at work?<br><b>1 □ Yes 2 □ No</b>                                   |  |  |  |
|  | 27. Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>   |  | 28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>28e. Baltimore Washington Medical Center Glen Burnie MD</b>                            |   |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 28a. Date of injury (Month, Day, Year)<br><b>28b. M</b>   |  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>  |   |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier<br><b>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>00055703</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 8, 2012</b>  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Baltimore Washington Medical Center Glen Burnie MD</b>   |  | 32. Registrar's Signature<br><b>Suzanne J. Gartland</b>  |   |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br><b>Suzanne J. Gartland</b>  |   |  |  |  |  |  |  |  |

HUIZINGA ARYS  
Baltimore, Maryland 21215-0036  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15200

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |  |  |   |  |   |   |   |   |  |  |
|-------------------------------------|--|--|--|---|--|---|---|---|---|--|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret F. Hart</b>  |  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>May 8, 2012</b>  |   | 3. Time of Death<br>11:30 P M   |  |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>5242 Wild Flower Terrace</b>  |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   | 4c. County of Death<br><b>Howard</b>                                    |  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>161-32-5762</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs. |   | If Under 1 Year<br>Months Days Hours Min.<br>   | If Under 24 Hrs.<br>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>August 15, 1939</b>        | 9. Birthplace (State or Foreign Country)<br><b>Florida</b>                                     |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Columbia</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     |  | 10e. Street and Number<br><b>5242 Wild Flower Terrace</b>  |  |   |  |   | 10f. Zip Code<br><b>21044</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|                                     |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br> |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | College (1-4 or 5+)<br><b>5+</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>   |   |   | 16b. Kind of Business/Industry<br><b>Medical</b>                        |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph L. Hillman</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lois J. Veal</b>  |   |   |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. John J. Hart (Husband)</b>  |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5242 Wild Flower Terrace Columbia, Maryland 21044</b> |   |   |  |  |
|                                     |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>MD Vet. Cemetery</i>  |  | 20b. Place of Disposition (Name of town or other place)<br><b>Crownsville MD Vet. Cemetery</b>  |  | Date<br><b>5-14-2012</b>  |   | 20c. Location - City or Town, State<br><b>Crownsville Maryland</b>  |   |  |  |
|                                     |  | 21. Signature of Funeral Service License<br><i>Michael J. Hart, Jr.</i>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md.</b>  |  | 21204   |   |   |   |  |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic Cancer</b><br>Approximate Interval Between Onset and Death<br><b>Months</b>  |  |   |  |   |   |   |   |  |  |
|                                     |  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |   |   |   |   |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown                |  | 23d. Date of delivery<br>Month Day Year   |   |   |   |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Uterine Cancer</b><br><b>Hypertension</b><br>23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |   |   |   |  |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>✓</i> |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>   |  | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |
|                                     |  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  |   |   |   |   |  |  |
|                                     |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |   |   |  |  |
|                                     |  | 29b. Signature and title of certifier<br><i>S. B. Hart MD</i>  |  |   |  |   | 29c. License number<br><b>DO057104</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 9th 2012</b>              |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7602 Belair Road, Baltimore, Maryland</b>   |  |   |  |   |   |   |   |  |  |
| State<br>Registrar                  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br><i>Frank J. Hart</i>   |  |   |   |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transcript.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15201

1. For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

|   |                        |   |   |   |                          |  |  |  |  |
|---|------------------------|---|---|---|--------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |                        |   |   | 2. Date of Death<br>Month May Day 6 Year 2012   |                          |  | 3. Time of Death<br>3:20 P M                                     |  |  |
| William Elton Kroh  |                        |   |   |   |                          |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)  |                        |   | 4b. City, Town, or Location of Death  |   |                          | 4c. County of Death                                    |  |  |  |
| Carroll Luth. Village Hlth. Care Ctr.   |                        |   | Westminster   |   |                          | Carroll  |  |  |  |
| 5. Social Security Number<br>220-03-5471<br>Usual Residence of Decedent   |                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>95 Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | Hours  | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>May 19, 1916   | 9. Birthplace (State or Foreign Country)<br>Maryland |
| 10a. State<br>Maryland  | 10b. County<br>Carroll | 10c. City, Town or Location<br>Westminster  |   |   |                          |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br>301 St. Luke Circle   |                        |   | 10f. Zip Code<br>21158  |   |                          | 10g. Citizen of What Country?<br>U.S.A.                |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.     |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11   |                        | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>typesetter/press operator; owner/operator |   | 16b. Kind of Business/Industry<br>newspaper/print shop  |                          |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Clinton Weaver Kroh  |                        |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Estella Bachman  |                          |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Samuel C. Hoff/ nephew  |                        |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1881 Amanda Lane |   |                          | Finksburg, MD 21048                                    |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>11 |                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Pipe Creek Cemetery   |   |   | Date<br>5/10/2012        | 20c. Location - City or Town, State<br>nr. Linwood, MD |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Katherine O. Karcher   |                        | 22. Name and Address of Facility<br>Hartzler Funeral Home, P.A.<br>310 Church St. New Windsor, MD 21776   |   |   |                          |  |  |  |  |

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |  |
|--|--|---|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.<br>shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |  |
| <p><i>2nd Stage Dementia</i></p> <p>{ Due to (or as a consequence of):</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p>   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive disease</i><br><i>Benign Prostatic Hyper trophy</i>   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 23f. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>20050763   |  |
| 29b. Signature and title of certifier<br>►   |  | 29d. Date signed (Month, Day, Year)<br>5/9/12   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type or Print)<br>826 Washington Rd<br>Westminster Md  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br>Ernesto Mendoza  |  |

State  
Registrar

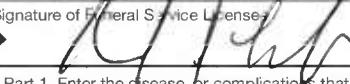
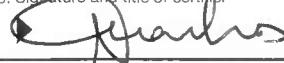
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15202

1 - For  
State  
Registrar

|  |   |  |   |   |   |   |  |  |  |
|--|---|--|---|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Kathleen Barranger Kohlerman</b>   |  |   |   |   | 2. Date of Death<br>Month<br><b>May</b>   | Day<br><b>03</b>   | Year<br><b>2012</b>  | 3. Time of Death<br><b>12:30 PM</b>  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist</b>  |  |   |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>                                       |  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-30-6387</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>83</b><br>Yrs. | If Under 1 Year<br>Months<br><input type="checkbox"/>   | If Under 24 Hrs.<br>Hours<br><input type="checkbox"/> | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 7, 1928</b>                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                |  |  |
|  | Usual Residence of Decedent<br><b>MD.</b>   |  | 10a. State<br><b>MD.</b>                            |   | 10b. County<br><b>Baltimore</b>                       |   | 10c. City, Town or Location<br><b>Towson</b>                               |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>8101 Bellona Ave.</b>   |   |  |   | 10f. Zip Code<br><b>21204</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>                                |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>5+</b>  |   | 16b. Kind of Business/Industry<br><b>Homemaker</b>  |   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles H. Barranger</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Geraldine Cross</b>   |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen K. D'Antonio/ Dtr.</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 Roundridge Rd. Timonium, MD. 21093</b>  |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem.</b>  |   |   | Date<br><b>5-15-12</b>   | 20c. Location - City or Town, State<br><b>Timonium, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.</b><br><b>1050 York Rd. Towson, md. 21204</b>   |   |   |  |  |  |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b> |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>Years</b>                                   |
|  | a. Due to (or as a consequence of):<br><b>Dementia</b>  |  |   |   |   |   |  |  |  |
| b. Due to (or as a consequence of):  |   |  |   |   |   |   |  |  |  |
| c. Due to (or as a consequence of):  |   |  |   |   |   |   |  |  |  |
| d. Due to (or as a consequence of):  |   |  |   |   |   |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown          |   |   |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |   |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M  |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D 58303</b>  |   |   |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 4 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AARON &gt; CHARLES MD 6701 N Charles St Towson MD</b>   |   |  |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   | 32. Registrar's Signature<br>   |   |   |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit document.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15203

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|   |  |   |  |   |
|---|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month 5 Day 11 Year 2012 5:15 p <sup>M</sup>  |  | 3. Time of Death  |
| <b>Mary Judith Lanni</b>  |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>4209 Jefferson Avenue</b>  |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>   |  | 4c. County of Death<br><b>Carroll</b>   |
| 5. Social Security Number<br><b>161-34-6296</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>71 Yrs.</b>                             | If Under 1 Year<br>Months      Days      Hours      Min.  |
| Usual Residence of Decedent<br><b>MD Carroll</b>  |  | 10c. City, Town or Location<br><b>Sykesville</b>  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 14, 1941</b>  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |
| 10e. Street and Number<br><b>4209 Jefferson Avenue</b>  |  | 10f. Zip Code<br><b>21784</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b>White</b>  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>4</b><br><b>Trainer</b>  |  | 16b. Kind of Business/Industry<br><b>Social Security</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Howard</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Brennan</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Mark Lanni (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4209 Jefferson Avenue, Sykesville, MD 21784</b>   |  |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>   |  | Date<br><b>5/19/2012</b>  |
| 20c. Location - City or Town, State<br><b>Sykesville, MD</b>  |  |   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Brian C. Haight MO0764</b>  |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL, PA<br/>PO Box 195 Sykesville, MD 21784</b>   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | a. Due to (or as a consequence of):<br><b>Pancreatic Cancer</b>   |  | Approximate Interval Between Onset and Death<br><b>Months</b>   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | b. Due to (or as a consequence of):   |  |   |
|   |  | c. Due to (or as a consequence of):   |  |   |
|   |  | d. _____  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>              |  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CVA, Diabetes, Hypertension, Smoker</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |  |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> 28d. Describe how injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>DOD 66448</b> 29d. Date signed (Month, Day, Year)<br><b>5/14/12</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7141 Security Blvd, Baltimore, MD 21244</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b> 32. Registrar's Signature<br><b>James S. Park</b>   |  |   |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15204

**Physician/  
Medical Examiner****1- For State  
Registrar**

|  |                      |  |  |  |                                    |                              |
|--|----------------------|--|--|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | Shavar Jerome Little |  |  |  | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1339 hrs |
|--|----------------------|--|--|--|------------------------------------|------------------------------|

|  |                        |  |  |  |   |                     |
|--|------------------------|--|--|--|---|---------------------|
| 4a. Facility Name (if not institution, give street and number) | Johns Hopkins Hospital |  |  |  | 4b. City, Town, or Location of Death<br>Baltimore | 4c. County of Death |
|--|------------------------|--|--|--|---|---------------------|

|  |  |                                      |                                |                                |   |  |
|--|--|--------------------------------------|--------------------------------|--------------------------------|---|--|
| 5. Social Security Number<br>213-04-6818 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>28 | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>6-4-1983 | 9. Birthplace (State or Foreign Country)<br>MD |
|--|--|--------------------------------------|--------------------------------|--------------------------------|---|--|

|                             |             |  |  |  |  |  |
|-----------------------------|-------------|--|--|--|--|--|
| Usual Residence of Decedent |             |  |  |  |  |  |
| 10a. State<br>MD            | 10b. County | 10c. City, Town or Location<br>Baltimore |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

|   |                        |                                      |
|---|------------------------|--------------------------------------|
| 10e. Street and Number<br>1327 N. Caroline Street | 10f. Zip Code<br>21213 | 10g. Citizen of What Country?<br>USA |
|---|------------------------|--------------------------------------|

|  |  |  |   |
|--|--|--|---|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Black<br>Specify: |
|--|--|--|---|

|   |  |  |
|---|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11 th | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) | 16b. Kind of Business/Industry<br>Home Improvement |
|---|--|--|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br>Eugene Robert Little | 18. Mother's Name (First, Middle, Maiden Surname)<br>Vanessa Crum |
|---|---|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print) Father Eugene Robert Little | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2445 Calvert St. Apt. 1 Balto, MD 21218 |
|--|--|

|  |   |                   |  |
|--|---|-------------------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br>Mount Zion Cem | Date<br>5-17-2012 | 20c. Location - City or Town, State<br>Lansdowne, MD |
|--|---|-------------------|--|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br><i>Phillip A Weatherford</i> | 22. Name and Address of Facility<br>Phillip A Weatherford FS PA<br>2431 E Oliver Street Balto MD 21213 |
|---|--|

|  |   |  |
|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | a. <b>Gunshot Wound of Head</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b.<br>Due to (or as a consequence of):                              |  |
| c.<br>Due to (or as a consequence of):   | d.  |  |
| <input type="checkbox"/> UNPENDED  | <input type="checkbox"/> AMENDED                                    |  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |   |   |
|---|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> EP/Outpatient 3 <input checked="" type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|---|

|  |  |                                 |   |   |
|--|--|---------------------------------|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>May 8, 2012  | 28b. Time of Injury<br>1303 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Subject shot   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br>Alley |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1100 Block of E. 20th Street, Baltimore, MD |

|  |
|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|--|

|  |                                 |  |
|--|---------------------------------|--|
| 29b. Signature and title of certifier<br><i>Laron Locke MD</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 9, 2012 |
|--|---------------------------------|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Laron Locke MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|--|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012 | 32. Registrar's Signature<br><i>Leron J. Parker</i> |
|--|---|

**Baltimore, MD 21215-0036**

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Shavar Jerome Little

**State  
Registrar**

DHMH 17 Rev 1/2001

OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15205

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

**Baltimore, Maryland 21215-0036**  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1

For  
State  
Registrar

Elizabeth Catherine Lange

2. Date of Death

Month

May

Day

12

Year

2012

3. Time of Death

2:20 A M

4a. Facility Name (if not institution, give street and number)

Lorien Mays Chapel

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

218-14-2624

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 2, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

10 Rumford Court

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married

3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary/ Bookkeeper

16b. Kind of Business Industry

Credit Union

17. Father's Name (First, Middle, Last)

Robert Forrester

18. Mother's Name (First, Middle, Maiden Surname)

Catherine E. Kroh

19a. Informant's Name/Relationship (Type, Print)

Philip Lange/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Hickory Meadow Rd. Cockeysville, MD. 21030

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State

4  Donation 5  Other (Specify)

New Cathedral Cem.

Date

5-16-12

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

Rick Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

22. Name and Address of Facility

Approximate Interval Between Onset and Death

4/20/12

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death

3  Ectopic pregnancy

4  Pregnant at time of death

5  Other (Specify)

9  Unknown

23d. Date of delivery

Month

Day

Year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death

3  Ectopic pregnancy

4  Pregnant at time of death

5  Other (Specify)

9  Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Uncontrolled Hypertension

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No

3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

Natural

Accident

Suicide

Homicide

Pending Investigation

Could not be determined

27. Manner of Death

Date of injury (Month, Day, Year)

Time of injury

1  Yes 2  No

28c. Injury at work?

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one 3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

6701 W. Charles St. Ste 4105 Towson, MD 21204

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 14 2012

James P. Jones

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

15206

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MILTON LIEBERGOT</b>  |  |  |  |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>7</b> Year <b>2012</b>                                       |  | 3. Time of Death<br>1:30 P M                          |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |  |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |  | 4c. County of Death<br><b>FREDERICK</b>               |  |
| 5. Social Security Number<br><b>058-03-0190</b>  |  | 6. Sex<br><b>1 X M 2 □ F</b>   | 7. Age (In yrs. last birthday)<br><b>97 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>01/11/1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b> |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>CHEVY CHASE</b>  |  |  |  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>      |  |
| 10e. Street and Number<br><b>4615 N. PARK AVENUE, APT. 1703</b>  |  |  |  | 10f. Zip Code<br><b>20815</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                    |   |  |
| 11. Marital Status<br><b>1 □ Never Married 2 X Married<br/>3 X Widowed 4 □ Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No<br/>If Yes, Give Year or Dates.</b>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> |  |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b> |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER</b>                                     |  |  |  | 16b. Kind of Business/Industry<br><b>LUNCHEONETTE</b>          |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRY LIEBERGOT</b>  |  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FANNIE UNKNOWN</b>                               |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HARRIS LIEBERGOT/SON</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>APT. 1703<br/>4615 N. PARK AVENUE, CHEVY CHASE, MD 20815</b> |  |  |  |  |   |  |
| 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 X Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MONTEFIORE CEMETERY</b>   |  | Date<br><b>05/10/2012</b>                            | 20c. Location - City or Town, State<br><b>JENKINTOWN, PA</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael Bruger</i>   |  |  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD, PIKEVILLE, MD 21208</b>  |  |  |  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><br><i>Congestive heart failure</i>                      |  |   |  |
| <p>a. Due to (or as a consequence of):<br/><br/><i>Congestive heart failure</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |  |  |  |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 X No<br/>9 □ Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b> |  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><i>Hypertension</i>  |  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b> |  |   |  |
|  |  |  |  |  |  |  | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 X No</b> |
| 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>       |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 3 □ Suicide 6 □ Could not be determined<br/>4 □ Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>  | 28d. Describe how injury occurred                    |  |  |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |   |  |
| 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><br><i>J</i>  |  | 29c. License number<br><b>D 57643</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/12</b> |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><br><i>Hiron or Shah no 65 c Thomas Thomson Dr</i>   |  |  |  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  |   |  |
|  |  |  |  |  |  |  | 32. Registrar's Signature<br><br><i>James S. Parker</i>  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15207

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

State  
Registrar

|  |  |   |  |   |   |   |  |  |
|--|--|---|--|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Suter Liskey</b>   |  |   |  |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>9</b> Year <b>2012</b>   | 3. Time of Death<br><b>10:55 AM</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>6047 Herring Bay Road</b>   |  |   |  |   |   |   | 4b. City, Town, or Location of Death<br><b>Deale</b>   | 4c. County of Death<br><b>Anne Arundel</b>                                 |
| 5. Social Security Number<br><b>217-38-1756</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months<br><input type="checkbox"/>   | If Under 24 Hrs.<br>Hours<br><input type="checkbox"/>   | Min.<br><input type="checkbox"/>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Mar 28, 1942</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Deale</b>   |   |   |  |  |
| 10e. Street and Number<br><b>6047 Herring Bay Road</b>   |  |   |  |   |   |   | 10f. Zip Code<br><b>20751</b>  | 10g. Citizen of What Country?<br><b>USA</b>                                |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>'60-62</b>  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>white</b> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>white</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>picture framer</b>             |   |   | 16b. Kind of Business/Industry<br><b>art</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest Liskey</b>  |  |   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Beecheum</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret B. Gregory/daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7100 Shamrock Drive Little Rock, AR 72205</b> |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Ronald S. Wade, Director</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  |   | Date  | 20c. Location - City or Town, State<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b> |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b>   |  |   |  |   |   |   | Approximate Interval Between Onset and Death<br><b>10 years</b>  |  |
| b. Due to (or as a consequence of):<br><b>HYPERTENSION</b>   |  |   |  |   |   |   |  |  |
| c. Due to (or as a consequence of):<br><b>HYPERLIPIDEMIA</b>   |  |   |  |   |   |   |  |  |
| d. _____   |  |   |  |   |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)           |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0039166</b>  |  |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>05-11-12</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>808 LANDMARK DR. STE 128 GLENBURNIE, MD 21061</b>   |  |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br><b>Anna S. Parker</b>  |  |   |   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15208

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 05 Day 05 Year 2012  |   |   |  | 3. Time of Death<br>3:05P M  |  |
| Lon Harvey Leedy   |  |  |   |   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>Joseph Ritchey Hospice   |  | 4b. City, Town, or Location of Death<br>Baltimore  |   |   |  | 4c. County of Death<br>N/A   |  |
| 5. Social Security Number<br>unk   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br>75 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>10/22/1936   | 9. Birthplace (State or Foreign Country)<br>Virginia |
| 6. Usual Residence of Decedent<br>N/A  |  | 10a. State<br>MD   |   |   |  | 10b. County<br>N/A   |  |
| 10c. City, Town or Location<br>Baltimore   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |
| 10e. Street and Number<br>3838 Roland Ave. #305  |  | 10f. Zip Code<br>21211   |   |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th Grade   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |   | 16b. Kind of Business/Industry<br>Marines   |  | N/A  |  |
| 17. Father's Name (First, Middle, Last)<br>Matthew Leedy   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lyda unk  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Amber Elliott (Grandchild)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1305 Anglesea St. Apt T4, Balto., MD 21224  |   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>on-site Crematory  |   | Date<br>5-9-12  | 20c. Location - City or Town, State<br>Baltimore, MD                                 |  |  |
| 21. Signature of Funeral Service Licensee<br>Jacqueline Sear   |  | 22. Name and Address of Facility<br>Joseph H. Brown Jr. Funeral Home PA<br>2140 N. Fulton Ave., Baltimore, MD 21217  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death<br>WEEKS  |  |
| a. <u>CEREBRAL INFARCT</u><br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |
| b. _____<br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |
| c. _____<br>Due to (or as a consequence of):   |  |  |   |   |  |  |  |
| d. _____   |  |  |   |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Coronary ARTERY DISEASE</u>   |  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) INPT Hospice  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><u>Marcel J. Horowitz</u>   |  | 29c. License number<br>DS5217  |   |   |  | 29d. Date signed (Month, Day, Year)<br>05/05/2012  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>MARCEL J. HOROWITZ 828 EWING ST, BALTIMORE, MD 21201</u>  |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br><u>Anna S. Garcia</u>   |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 30, per DVR, g927 5-14-12 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15209

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Milburn, Robert

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Hour Min.   |   |
| <b>Robert C. Milburn</b>  |  | 5/10/2012   |   | 1718 M  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death   |   |
| 5. Social Security Number<br><b>216-54-6243</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>60</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-21-1951</b>  |
| 10a. State<br><b>MD</b>   |  | 10b. County   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>1113 Wildwood Par Kway</b>   |  | 10f. Zip Code<br><b>21229</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: <b>Black</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Body Repair Technician</b>  |   | 16b. Kind of Business/Industry<br><b>Self Employed</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Robert R. Milburn</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary J. Thompson</b>  |   |   |   |
| 19. Informant's Name/Relationship (Type, Print)<br><b>Mary J. Milburn (Mother)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1113 W. Wildwood Parkway, Baltimore, MD 21229</b>   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Loudon Park</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park</b>  |   | Date<br><b>5-18-12</b>  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |
| 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>  |  | 22. Name and Address of Facility<br><b>Vaughn C. Greene Funeral Services<br/>5151 Baltimore Nat'l Pike (21229)</b>  |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br><b>1-2 days</b>   |   |   |   |
| a. <b>Severe CHF</b><br>Due to (or as a consequence of):<br><b>Septic shock</b>   |  |   |   |   |   |
| b. Due to (or as a consequence of):<br><b>Hypoglycemia</b>  |  |   |   |   |   |
| c. Due to (or as a consequence of):   |  |   |   |   |   |
| d.  |  |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute on chronic kidney disease</b>  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown              |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |   | 23f.  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                           |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |   |
| 29b. Signature and title of certifier<br><b>Ashima M.D.</b>   |  | 29c. License number<br><b>P25484</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/10/2012</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Srivastava, Ashima</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |   |   |   |
|   |  | 32. Registrar's Signature<br><b>Renuka P. Patel</b>   |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15210

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Baltimore, Maryland 21215-0036

Manigault, Edgar D.  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |             |   |   |   |
|--|-------------|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |             | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Hour AM/PM  |
| <i>Edgar Dennis Manigault</i>  |             | May 11 2012   |   | 10:01 A M   |
| 4a. Facility Name (if not institution, give street and number)<br><i>Saint Agnes Hospital</i>  |             | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |   | 4c. County of Death   |
| 5. Social Security Number<br><i>248-48-5572</i>  |             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><i>79</i><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>If Under 24 Hrs.<br>Specify:   |
| 8. Date of Birth<br>(Month, Day, Year)<br><i>9-18-1932</i>   |             | 9. Birthplace (State or Foreign Country)<br><i>SC</i>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
| 10a. State<br><i>MD</i>  | 10b. County | 10c. City, Town or Location<br><i>Baltimore</i>   |   |   |
| 10e. Street and Number<br><i>205 N. Monastery Avenue</i>   |             | 10f. Zip Code<br><i>21229</i>   |   | 10g. Citizen of What Country?<br><i>USA</i>   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><i>1945-1948</i>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><i>Black</i> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>2</i>  |             | 16a. Decedent's Usual Occupation<br>(the kind of work done during most of working life DO NOT use retired)<br><i>Postal Clerk</i>   |   | 16b. Kind of Business/Industry<br><i>United States Postal Service</i>   |
| 17. Father's Name (First, Middle, Last)<br><i>Thomas Manigo</i>  |             | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Simmons</i>  |   |   |
| 19a. Informant's Name/Relationship (Type)<br><i>Zafia Mahasa</i>   |             | 19b. Mailing Address/Street and Number or Rural Route Number, City or Town, State, Zip Code<br><i>3322 Moravia Road, Baltimore, MD 21214</i>  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><i>Vaughn C. Greese</i>   |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest</i>  |   | Date<br><i>5-21-12</i>  |
| 21. Signature of Funeral Service Licensee<br><i>Vaughn C. Greese</i>   |             | 22. Name and Address of Facility<br><i>Vaughn C. Greese Funeral Services<br/>5151 Baltimore National Pike (21229)</i>   |   | 20c. Location - City or Town, State<br><i>Owings Mills, MD</i>  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Cardiopulmonary arrest</i>  |             |   |   |   |
| Approximate Interval Between Onset and Death<br><i>1 hour</i>  |             |   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Hypertension</i><br><i>Diabetes mellitus</i>  |             |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |             | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |   |
| 23d. Date of delivery<br>Month Day Year  |             |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |             |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |             | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |             | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             | 29c. License number<br><i>DS0708</i>  |   |   |
| 29b. Signature and title of certifier<br><i>Kraig Melville</i>   |             | 29d. Date signed (Month, Day, Year)<br><i>5/10/12</i>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Kraig Melville 900 S. Calm Avenue Baltimore, MD</i>   |             |   |   |   |
| 31. Date filed (Month, Day, Year)<br><i>MAY 14 2012</i>  |             | 32. Registrar's Signature<br><i>James J. Park</i>   |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15211

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen E. Markas

2. Date of Death

MAY 11 Day

3. Time of Death

8:08A M

Funeral Director  
To Be Completed by Funeral Director

Stephen E. Markas, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner  
To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death.

3 gm

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15212

**1- For State Registrar****Physician/Medical Examiner**

1. Decedent's Name (First, Middle Last)

GLENN Stephen Montague

2. Date of Death

Month

Day

Year

3. Time of Death

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## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #8 Per EH C928 6/29/2012 JH  
 &#33State of Maryland Department of Health and Mental Hygiene

## Certificate of Death

2012 15213

Reg. No.

|  |  |   |  |   |   |  |                                     |  |                                     |   |   |
|--|--|---|--|---|---|--|-------------------------------------|--|-------------------------------------|---|---|
| 1- For State Registrar   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Gregory Dean Martin</b>  |  |   |   |  |                                     | 2. Date of Death<br>Month <b>May</b> Day <b>04</b> , Year <b>2012</b>  |                                     | 3. Time of Death<br>9:35pm<br>2:35 pm                       |   |
| Physician/ Medical Examiner  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |   |  |                                     | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |                                     | 4c. County of Death<br><b>Montgomery</b>                    |   |
| Funeral Director   |  | 5. Social Security Number<br><b>215-58-9568</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b><br>Yrs. |  | If Under 1 Year<br>Months      Days |  | If Under 24 Hrs.<br>Hours      Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>07 07 1951</b> | 9. Birthplace (State or Foreign Country)<br><b>DC</b> |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |                                     | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                     |   |   |
|  |  | 10e. Street and Number<br><b>164 Gold Kettle Dr.</b>  |  |   |   | 10f. Zip Code<br><b>20878</b>  |                                     | 10g. Citizen of What Country?<br><b>USA</b>  |                                     |   |   |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |                                     |   |   |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>2</b>   |   | Home Contractor  |                                     | 16b. Kind of Business/Industry<br><b>Home Repair</b>   |                                     |   |   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>William Henry Martin</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jane Davy</b>   |                                     |  |                                     |   |   |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Martin/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>164 Gold Kettle Dr. Gaithersburg, MD 20878</b>  |   |  |                                     |  |                                     |   |   |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>►Rebecca Hocherman NO 1585</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crem.</b>   |   | May 8, 2012  |                                     | 20c. Location - City or Town, State<br><b>Beltsville, MD</b>   |                                     |   |   |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Rebecca Hocherman</b>   |  | 22. Name and Address of Facility<br><b>Rapp Funeral &amp; Cremation Services</b><br><b>933 Gist Ave. Silver Spring, MD 20910</b>  |   |  |                                     |  |                                     |   |   |
| Physician/ Medical Examiner  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Colon Cancer</b>  |  |   |   |  |                                     | Approximate Interval Between Onset and Death   |                                     |   |   |
|  |  | a. Due to (or as a consequence of):<br><b>Pneumonia</b>   |  |   |   |  |                                     |  |                                     |   |   |
|  |  | b. Due to (or as a consequence of):<br><b>Acute Small Bowel Obstruction</b>   |  |   |   |  |                                     |  |                                     |   |   |
|  |  | c. Due to (or as a consequence of):<br><b>d.</b>  |  |   |   |  |                                     |  |                                     |   |   |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |                                     |  |                                     |   |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |                                     | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                     |   |   |
|  |  |   |  |   |   |  |                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                     |   |   |
|  |  |   |  |   |   |  |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                     |   |   |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                                     |  |                                     |   |   |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred   |  |                                     |   |   |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                     |  |                                     |   |   |
|  |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |                                     |  |                                     |   |   |
|  |  | 29b. Signature and title of certifier<br><b>►C Maheshwary MD</b>  |  | 29c. License number<br><b>D0068681</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b>  |                                     |  |                                     |   |   |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Charu Maheshwary 1500 Forest Glen Rd. Silver Spring, MD 20910</b>  |  |   |   |  |                                     |  |                                     |   |   |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br><b>Laura S. Patel</b>  |   |  |                                     |  |                                     |   |   |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012

15214

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |   |   |  |                           |  |  |   |  |
|--|--|---|---|--|---------------------------|--|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Nelson</b>   |   |  |                           | 2. Date of Death<br>Month <b>MAY</b> Day <b>10</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>3:00 P M</b>   |  |
|  |  | 4a. Facility Name (If not institution, give street and number)<br><b>Season's Hospice</b>   |   |  |                           | 4b. City, Town, or Location of Death<br><b>Randallstown</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral Director   |  | 5. Social Security Number<br><b>215-32-5284</b>   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>   | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>1-28-1924</b> | 9. Birthplace (State or Foreign Country)<br><b>NC</b>   |  |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>MD</b>   |   |  |                           | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Randallstown</b>  |  |
|  |  | 10e. Street and Number<br><b>9728 Mendoza Road</b>  |   |  |                           | 10f. Zip Code<br><b>21133</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.   |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |                           | 16b. Kind of Business/Industry<br><b>Baltimore City</b>  |  |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>James Adams</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosean Biggers</b>   |                           |  |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shelley R. Spears Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9728 Mendoza Road Randallstown, MD 21133</b>   |                           |  |  |   |  |
|  |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial</b>  |                           | Date<br><b>5-19-2012</b>   | 20c. Location - City or Town, State<br><b>Baltimore MD</b> |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Ghane</b>   |   | 22. Name and Address of Facility<br><b>Vaughn C. Ghane Funeral Services<br/>8738 Liberty Road Randallstown, MD 21133</b>   |                           |  |  |   |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Atherosclerotic Cardiovascular Disease</b>   |   |  |                           |  |  | Approximate Interval Between Onset and Death  |  |
|  |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):  |   |  |                           |  |  |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b> |                           | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |                           |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
|  |  |   |   |  |                           |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
|  |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: <b>in-patient hospice</b>   |                           | Other:<br><b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)</b> |  |   |  |
|  |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>  |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred                          |   |  |
|  |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |                           |  |  |   |  |
|  |  | 29b. Signature and title of certifier<br><b>N Rajapakse MD</b>  |   | 29c. License number<br><b>D0057465</b>   |                           | 29d. Date signed (Month, Day, Year)<br><b>5/10/12</b>  |  |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N Rajapakse MD 2835 Smith AV S 203 Baltimore MD 21209</b>  |   |  |                           |  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |   | 32. Registrar's Signature<br><b>Jeanne D. Parker</b>   |                           |  |  |   |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10/8/12

State  
Registrar

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amend 18, per th, g927 5-14-12 sm

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15215

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)                       | 2. Date of Death<br>Month Day Year                                   |  |  | 3. Time of Death<br>Hour:Minute AM/PM  |
| Babajide Oyefeso   | May  | 8  | 2012   | 7:15 PM                                |
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death                                 |  |  | 4c. County of Death                    |
| Seasons Hospice & NW Hospital                                  | Randallstown   |  |  | Baltimore                              |
| 5. Social Security Number                                      | 6. Sex   | 7. Age (In yrs. last birthday)           | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year) |
| 219-96-9423  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 52 Yrs.                                  |  | 06/07/1959                             |
| Usual Residence of Decedent                                    |  | 9. Birthplace (State or Foreign Country) |  |  |
| 10a. State   | 10b. County  | 10c. City, Town or Location              | Nigeria  |  |
| MD   | Baltimore  | Windsor Mill                             | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Baltimore, Maryland 21215-0036

## Division of Vital Records, P.O. Box 68760

**To Be Completed by Funeral Director****Medical Certificate: To Be Completed by Physician/Medical Examiner****State  
Registrar**

|  |   |  |  |  |   |
|--|---|--|--|--|---|
| 10pm   | 10. Street and Number   | 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: Black |
| 1 Woodlawn Court   | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:                          |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)   | Elementary/Secondary (0-12)<br>12th grade   | College (1-4 or 5+)<br>5+ years  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry<br>State of MD  |   |
| 17. Father's Name (First, Middle, Last)  | Computer Programmer   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Comfort Abesede Olabowale                               |   |
| 19a. Informant's Name/Relationship (Type, Print)   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  | 45231  |   |
| Tayo Banjo (daughter)  | 7905 Rambleview Unit 302 Cincinnati OH  |  |  |  |   |
| 20a. Method of Disposition   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  | Date   | 20c. Location - City or Town, State  |  |   |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   | Dixie Ridge Cemetery  | 05/15/2012   | Pikesville, MD   |  |   |
| 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility  | Vaughn C. Greene Funeral Services<br>8728 Liberty Road Randallstown MD 21133                           |  |  |   |
| ► Vaughn C. Greene   |   |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   |  |  |  | Approximate Interval Between Onset and Death                  |
| Breast Cancer  |   |  |  |  |   |
| a. Due to (or as a consequence of):  |   |  |  |  |   |
| b. Due to (or as a consequence of):  |   |  |  |  |   |
| c. Due to (or as a consequence of):  |   |  |  |  |   |
| d. _____   |   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>g <input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> in-patient hospice |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                         | 28d. Describe how injury occurred  |   |
| 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                           |  |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |   |
| 29b. Signature and title of certifier<br>► N.S. Rayapati, MD   | 29c. License number<br>DOUG 7465  | 29d. Date signed (Month, Day, Year)<br>5/19/12   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | N.S. Rayapati, MD 2835 Smith Av #203 Baltimore MD 21209   |  |  |  |   |
| 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature<br>Lorraine J. Parker   |  |  |  |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15216

1- For  
State  
Registrar

|  |   |  |   |  |  |   |   |  |  |
|--|---|--|---|--|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Esther Mae Cunningham Ryan</b>   |  |   |  |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>11</b> Year <b>2012</b>  | 3. Time of Death<br><b>0205M</b>                             |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>BrookeGrove Assisted Living - Woods</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Sandy Spring</b>  |  |   | 4c. County of Death<br><b>Montgomery</b>              |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>448-18-1676</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><b>88</b><br>Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept 7, 1923</b>                               | 9. Birthplace (State or Foreign Country)<br><b>OK</b> |  |  |
|  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Sandy Spring</b>   |  |   |  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1612 Hickory Knoll Road</b>   |   |  |   | 10f. Zip Code<br><b>20860</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>           |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |   |  | 16b. Kind of Business Industry<br><b>Food Service</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Cunningham</b>  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Angelina Wright</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. William Ryan (Son/Executor)</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44626 Joy Chapel Road, Hollywood, MD 20636</b> |  |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>All County Cremation</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>  |   |  | Date<br><b>5/12/2012</b>   | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>                                |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian L. Haugt MO0764</b>  |   |  |   | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL, P.A.<br/>PO Box 195 Sykesville, MD 21784</b>                              |  |   |   |  |  |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>restrictive lung disease</b> |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>years</b> |
|  | b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |  |   |  |  |   |   |  |  |
| 23b. If FEMALE:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>assisted living</b> |   |  |  |   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure; type 2 diabetes mellitus</b>  |   |  |   |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A  |   |  |  |   |   | 23f. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Grace Brooke Hoffman, M.D., 18100 Slade School Road Sandy Spring Maryland 20860</b>                           |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br><b>D42046</b>   |   |  |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>May 11, 2012</b>   |  |
| 29b. Signature and title of certifier<br><b>John no attending physician</b>  |   |  |   |  |  |   |   |  |  |
| 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Grace Brooke Hoffman, M.D., 18100 Slade School Road Sandy Spring Maryland 20860</b>   |   |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   | 32. Registrar's Signature<br><b>Anna J. Park</b>   |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

H/V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30 per DVR, G927, 5/14/2012, WS  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15217

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department. If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death   |
| <b>Scott Norman Randall</b>  |  | 5 10 2012   |  | 10044M   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Ft Washington Medical</b>   |  | 4b. City, Town, or Location of Death<br><b>Ft. Washington</b>   |  | 4c. County of death<br><b>PG.</b>  |
| 5. Social Security Number<br><b>567-17-5332</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>51 Yrs.  |
|  |  | If Under 1 Year<br>Months Days Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br>7-24-1960  |
|  |  |   |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PG</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>17810 Indian Head Hwy</b>   |  | 10f. Zip Code<br><b>20607</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:          |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>T+4</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DQ NOT use retired)<br><b>Self-employed</b>  |  | 16b. Kind of Business Industry<br><b>Dog Boarding and Grooming</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Harold Norman Randall JR.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marilyn Theall</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marilyn Theall Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17810 Indian Head Highway 20607</b>   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Michael Service</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rivendale Park</b>   |  | 20c. Date<br><b>5-12-2012</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Michael Service</b>  |  | 22. Name and Address of Facility<br><b>Wiseman Funeral Home<br/>4527 Old Alexandria Ferry Rd Clinton MD 20735</b>   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Asthma</b>  |  |   |  | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | {<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. _____  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D46741</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Deepak Sachdeva, MD</b>   |  | 32. Registrar's Signature<br><b>Deepak Sachdeva</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15218

1 - For  
State  
Registrar

|  |  |   |   |  |  |  |  |   |
|--|--|---|---|--|--|--|--|---|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>CAROLYN M. SUTTON</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>May 7 2012</b>        | 3. Time of Death<br>Hour Minute<br><b>1035 AM</b>  |  |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>10204 Bird River Road</b>   |   | 4b. City, Town, or Location of Death<br><b>Middle River</b>   |  | 4c. County of Death<br><b>Baltimore Co.</b>                    |  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-42-3424</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.<br>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 28, 1944</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |
|  | Usual Residence of Decedent<br><b>MD Baltimore</b>   |   | 10c. City, Town or Location<br><b>Middle River</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>10204 Bird River Road</b>   |   |   | 10f. Zip Code<br><b>21220</b>  | 10g. Citizen of What Country?<br><b>United States</b>          |  |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10 Years</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Communications</b> |  | 16b. Kind of Business/Industry<br><b>Oak Crest</b>             |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Edward Appler</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Corrine M. Gocheimmer</b>  |  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Charles W. Sutton, Sr.</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10204 Bird River Road Middle River, MD 21220</b>      |  |  |  |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem Gdns.</b>   |  | Date<br><b>5/11/2012</b>                                       | 20c. Location - City or Town, State<br><b>Middle River, MD</b>                                 |  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Michael Neiser</b>   |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                             |  |  |  |  |   |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Emphysema</b>   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>   |   |
|  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>  |   |   |  |  |  |  |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>Unknown</b>   |   |   |  |  |  | 23d. Date of delivery<br>Month Day Year<br>  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>   |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Residence</b>  |   |   |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br>4 <input type="checkbox"/> Homicide |   |
|  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury<br/>M</b><br>28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  | 28d. Describe how injury occurred<br>  |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |   |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, MD 21220</b>   |   |
|  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  | 29b. Signature and title of certifier<br><b>Carolyn Bob</b>  |   |
|  | 29c. License number<br><b>D15872</b>   |   |   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b>  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barbara BCB, 6954 Princeton Blvd Aven Barriap 21061</b>   |   |   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   |
|  | 32. Registrar's Signature<br><b>Barbara BCB, 6954 Princeton Blvd Aven Barriap 21061</b>  |   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15219

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

MAY 7, 2012 8:40 p.m.

Baltimore, Maryland 21215-0036

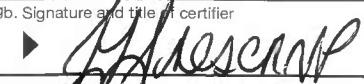
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

EDWARD SCHULZ

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |                                 |  |   |   |   |  |   |
|--|---------------------------------|--|---|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |                                 | 2. Date of Death<br>Month May Day 2012 Year  |   |   |   | 3. Time of Death<br>8:40 P M   |   |
| Edward Casper Schultz, Jr.   |                                 |  |   |   |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Stella Maris Hospice Center</b>   |                                 | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |   |   |   | 4c. County of Death<br><b>Baltimore Co.</b>  |   |
| 5. Social Security Number<br><b>216-54-5002</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>64</b><br>Yrs. | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 9, 1947</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent  |                                 |  |   |   |   |  |   |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Essex</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>25 Clipper Road</b>   |                                 |  |   | 10f. Zip Code<br><b>21221</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 Years</b>  |                                 | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 2 Years Engineer</b>  |   | 16b. Kind of Business/Industry<br><b>Technology</b>   |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Casper Schultz, Sr.</b>   |                                 |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Celestina Catherine Miletto</b>   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Lynnette A. Schultz (Wife)</b>   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25 Clipper Road Essex, Maryland 21221</b>  |   |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Ht. of Jesus</b>   |   | Date<br><b>Dem. 5/10/2012</b>   | 20c. Location - City or Town, State<br><b>Dundalk, Maryland</b>                             |  |   |
| 21. Signature of Funeral Service Licensee<br>   |                                 | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b><br><b>7922 Wise Ave. Dundalk, Maryland 21222</b>  |   |   |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                                 | Approximate Interval Between Onset and Death   |   |   |   |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |                                 |  |   |   |   |  |   |
| a. <b>LYMPHOMA</b><br>Due to (or as a consequence of):<br>  |                                 |  |   |   |   |  |   |
| b. Due to (or as a consequence of):  |                                 |  |   |   |   |  |   |
| c. Due to (or as a consequence of):  |                                 |  |   |   |   |  |   |
| d. _____   |                                 |  |   |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                                 | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown          |   |   |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                 | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |   |
|  |                                 |  |   |   |   |  |   |
|  |                                 |  |   |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |                                 | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |   |
|  |                                 |  |   |   |   |  |   |
|  |                                 |  |   |   |   |  |   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   |  |   |
| 29b. Signature and title of certifier<br>   |                                 | 29c. License number<br><b>B149792</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/8/2012</b>  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |                                 |  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |                                 | 32. Registrar's Signature<br>   |   |   |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15220  
Certificate of Death Reg. No.

1- For State Registrar

Physician/  
Medical  
Examiner

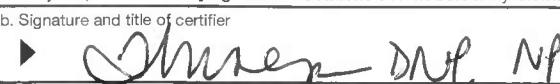
Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |   |   |
|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month May Day 9 Year 2012  |   | 3. Time of Death<br>2:00 AM   |
| Franklin Richard Svrjcek, Sr.  |  | 4a. Facility Name (if not institution, give street and number)<br>Stella Maris Hospice Center  |   | 4b. City, Town, or Location of Death<br>Timonium  |
| 5. Social Security Number<br>216-14-4838   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>89 Yrs. | If Under 1 Year<br>Months Days Hours Min.   |
| Usual Residence of Decedent<br>Baltimore   |  | 8. Date of Birth<br>(Month, Day, Year)<br>Jan. 8, 1923   |   |   |
| 10a. State<br>MD   |  | 10b. County<br>Baltimore   |   | 10c. City, Town or Location<br>Dundalk  |
| 10e. Street and Number<br>2411 Meadow Road   |  | 10f. Zip Code<br>21222   |   | 10g. Citizen of What Country?<br>United States  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Years  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |   | 16b. Kind of Business/Industry<br>Machinist Tool Manufacturing  |
| 17. Father's Name (First, Middle, Last)<br>Joseph E. Svrjcek   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Camilla M. Zika   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Ellen V. Svrjcek (Wife)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2411 Meadow Road Dundalk, Maryland 21222  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Ht. of Jesus Cem. 5/12/2012   |   | Date<br>5/12/2012   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222  |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |   |
| a. Due to (or as a consequence of):<br><br>BLADDER CANCER  |  |  |   |   |
| b. Due to (or as a consequence of):  |  |  |   |   |
| c. Due to (or as a consequence of):  |  |  |   |   |
| d. _____   |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of Injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |
|  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>R130272   |   |   |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br>5/9/2012  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br>   |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

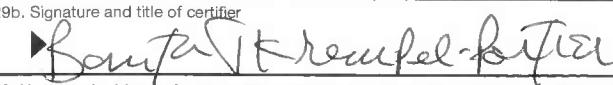
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15221

Reg. No.

1- For  
State  
Registrar

|   |  |  |  |  |   |  |   |   |  |
|---|--|--|--|--|---|--|---|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ann Sparkman</b>   |  |  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b> | 3. Time of Death<br><b>4:21 A M</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>11401 Renner Rd.</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Ladiesburg</b>  |   |  | 4c. County of Death<br><b>Frederick</b>                             |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>214-50-5055</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65 Yrs.</b>   |   | If Under 1 Year<br>Months <b> </b> Days <b> </b> | If Under 24 Hrs.<br>Hours <b> </b> Min. <b> </b>                    | 8. Date of Birth<br>(Month, Day, Year)<br><b>Mar. 4, 1947</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
|   | Usual Residence of Decedent<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Ladiesburg</b>                    |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <b>To Be Completed by Funeral Director</b>  | 10e. Street and Number<br><b>11401 Renner Rd.</b>  |  |  |  | 10f. Zip Code<br><b>21759</b>   |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b>   |  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>production supervisor</b> |   |  | 16b. Kind of Business/Industry<br><b>respirator mfg.</b>            |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Minkosky</b>   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara E. Clem</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michelle Dinterman/ daughter</b>   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11562 Buffington Rd. Woodsboro, MD 21798</b>  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>  |   |  | Date<br><b>5/16/2012</b>  | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Hartzler Funeral Home, P.A.<br/>404 S. Main St. Woodsboro, MD 21798</b>                               |   |  |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ENDSTAGE COPD</b>  |  |  |  |  |   |  |   |   |  |
| Approximate Interval Between Onset and Death  |  |  |  |  |   |  |   |   |  |
| Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>TABACCO DEPENDENCE</b>   |  |  |  |  |   |  |   |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |  |  |  |   |  |   |   |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____   |  |  |  |  |   |  |   |   |  |
| 23d. Date of delivery<br>Month <b> </b> Day <b> </b> Year <b> </b>  |  |  |  |  |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic cardiomyopathy</b>  |  |  |  |  |   |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  |  |  |  |   |  |   |   |  |
| 28a. Date of injury (Month, Day, Year)<br><b> </b> 28b. Time of injury<br><b>M</b> 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |   |  |   |   |  |
| 28d. Describe how injury occurred   |  |  |  |  |   |  |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |   |   |  |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |  |  |  |   |  |   |   |  |
| 29c. License number<br><b>10044034</b>  |  |  |  |  |   |  |   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>05-11-2012</b>  |  |  |  |  |   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bonita J. Krempel-Portier 121-123 W. Main St. Rear Emmitsburg, MD 21727</b>  |  |  |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  |  |  |  | 32. Registrar's Signature<br>                                  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7V

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15222

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death  |   | 3. Time of Death  |
| Paul Lawrence Tinson Sr.   |  | Month   | Day                                       | Year  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death   |
| 8911 Talc Drive #3A  |  | Rosedale  |   | Baltimore   |
| 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. last birthday)  | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)  |
| 218-11-2489  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 40 Yrs.   |   | 10/12/1971  |
| Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)  |   |   |
| MD Baltimore   |  | Maryland  |   |   |
| 10a. State   | 10b. County  | 10c. City, Town or Location   |   |   |
| MD   | Baltimore  | Rosedale  |   |   |
| 10e. Street and Number   |  | 10f. Zip Code   |   | 10g. Citizen of What Country?   |
| 8911 Talc Drive #3A  |  | 21237   |   | USA   |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |   | 16b. Kind of Business/Industry  |
| Elementary/Secondary (0-12) 12   |  | College (1-4 or 5+) 0   |   | Baltimore City Police Department  |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |   |   |
| Lawrence Tinson  |  | Roxie Abram   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |   |   |
| Mrs. Lavonna Tinson wife   |  | 8911 Talc Drive #3A Rosedale, MD 21237  |   |   |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | King Memorial Park  |   | 5/18/2012   |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home, P.A.<br>2222 W. North Ave. Balt., MD 21216   |   |   |
| Dyssey Gray  |  |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |   |
| Immediate Cause (Final disease or condition resulting in death)  |  |   |   |   |
| a. suicide Gun shot wound to head  |  |   |   |   |
| Due to (or as a consequence of):   |  |   |   |   |
| b. _____   |  |   |   |   |
| c. _____   |  |   |   |   |
| d. _____   |  |   |   |   |
| Approximate Interval Between Onset and Death   |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   |
|  |  | 23d. Date of delivery<br>Month Day Year   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br>5/10/2012  | 28b. Time of injury<br>9:32 AM            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  |  | 28d. Describe how injury occurred<br>self inflicted<br>gun shot to head   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>home  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>8911 Talc Dr. #3A Rosedale, MD 21237   |  |   |   |   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>DI 8667  |   |   |
| 29b. Signature and title of certifier<br>H. R. Miller MD Deputy  |  | 29d. Date signed (Month, Day, Year)<br>May 11, 2012   |   |   |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>Philip M. Milletello, MD 6 Trumble Hill Ct Lutherville, Md 21093   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br>Suzanne A. Parks   |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15223

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Garland Woodward</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b>   | 3. Time of Death<br><b>9:00 p m</b>   |  |                                   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Transitions Health Care</b>   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>   |   |  |                                   |
| 4c. County of Death<br><b>Carroll</b>  |  |   |   |  |                                   |
| 5. Social Security Number<br><b>225-24-3696</b>  |  | 6. Sex<br><b>M</b>  | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs.   |  |                                   |
|  |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.   |  |                                   |
|  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan 3 1925</b>   |   |  |                                   |
|  |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>   |   |  |                                   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   | 10c. City, Town or Location<br><b>Westminster</b>   |  |                                   |
| 10d. Inside City Limits<br><b>Yes</b>  |  | 10e. Street and Number<br><b>1904 Don Avenue</b>  |   |  |                                   |
| 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |                                   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>WWII</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:<br><b>white</b> |  |                                   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>nursing assistant</b>  | 16b. Kind of Business Industry<br><b>health care</b>  |  |                                   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Edward Woodward</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fanny Souris</b>  |   |  |                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Sandra Lay (daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1904 Don Avenue, Westminster, MD 21157</b>  |   |  |                                   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Memorial</b>   | Date<br><b>5-15-12</b>  |  |                                   |
| 21. Signature of Funeral Service Licensee<br><b>Diane Haight Herbert</b>   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784</b>   |   |  |                                   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>Years</b>  |   |  |                                   |
| <p>a. Due to (or as a consequence of):<br/><b>Dementia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |  |   |   |  |                                   |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |                                   |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |                                   |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |                                   |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>00058137</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/11/12</b>                                |                                   |
| 29b. Signature and title of certifier<br><b>Diane H. Herbert MD</b>  |  |   |   |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wilbur Kus 295 Stone Ave St 307 Westminster MD 21157</b>  |  |   |   |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |  | 32. Registrar's Signature<br><b>Diane J. Gable</b>  |   |  |                                   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

gov

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15224

1 - For State Registrar

|   |   |   |   |  |  |   |  |  |
|---|---|---|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                 | 1. Decedent's Name (First, Middle, Last)<br><i>Genevieve Williams</i>   |   |   |  | 2. Date of Death<br>Month <b>5</b> Day <b>9</b> Year <b>2012</b>                 | 3. Time of Death<br><b>5:53 P.M.</b>                                    |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><i>8122 Pleasant Plains Rd Towson</i>   |   | 4b. City, Town, or Location of Death<br><i>Towson</i>   |  | 4c. County of Death<br><i>Baltimore</i>  |   |  |  |
| Funeral Director  | 5. Social Security Number<br><b>220-14-4868</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b><br>Yrs.   | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct 28, 1923</b>                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |
| To Be Completed by Funeral Director                               | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Towson</b> 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |  |  |
|   | 10e. Street and Number<br><b>8122 Pleasant Plains Rd.</b>   |   | 10f. Zip Code<br><b>21286</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                            |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><i>2</i> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i></i> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>   |  |  | 16b. Kind of Business Industry<br><b>Own Home</b>                       |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John O'Neill</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Agnes Thuman</b>  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Williams /Son</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 Dunbeath Ct. Lutherville Timonium, MD 21093</b>   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                 | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i></i>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Date <b>May 11, 2012</b>   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>      |  |  |
| Medical Certificate To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Syndra Lee Ritter MO1443</i>  |   | 22. Cremation and Funeral Alternatives<br><b>8717 Green Pastures Drive Towson Maryland 21286</b>  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Dementia</i>   |   |   |  |  |   | Approximate Interval Between Onset and Death   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i></i>   |   |   |  |  |   |  |  |
|   | a. Due to (or as a consequence of):<br><i></i>  |   |   |  |  |   |  |  |
|   | b. Due to (or as a consequence of):<br><i></i>  |   |   |  |  |   |  |  |
|   | c. Due to (or as a consequence of):<br><i></i>  |   |   |  |  |   |  |  |
|   | d. Due to (or as a consequence of):<br><i></i>  |   |   |  |  |   |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year                                 |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>renal insufficiency, atrial fibrillation</i>   |   |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |  |
|   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |  |
|   | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>only one |   | 29c. License number<br><b>D34988</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5-10-2012</b>                          |   |  |  |
|   | 29b. Signature and title of certifier<br><i>David A. Roberts, M.D.</i>  |   |   |  |  |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>David A. Roberts, M.D. 10753 Falls, suite 205, Lutherville, Md 21093</i>   |   |   |  |  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |   | 32. Registrar's Signature<br><i>Laura J. Gaskin</i>   |  |  |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15225

1 For  
State  
RegistrarPhysician/  
Medical  
Examiner

|   |  |   |                                |  |  |  |   |  |  |
|---|--|---|--------------------------------|--|--|--|---|--|--|
|   |  | 1. Decedent's Name (First, Middle, Last)  |                                |  | 2. Date of Death                                       |  |   | 3. Time of Death   |  |
|   |  | Kathryn Mary Love Reddington Young  |                                |  | Month<br>May   |  |   | Day<br>10 Year<br>2012<br>4:20 PM  |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                                |  | 4c. County of Death                                    |  |   |  |  |
| 12300 Rosslyn Ridge Rd. #506  |  | Timonium  |                                |  | Baltimore  |  |   |  |  |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) |  | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birth  | 9. Birthplace (State or Foreign Country)                                     |  |
| 214-36-9027   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 73                             | Yrs.   | Months   | Days   | Month Day Year<br>May 05, 1939  | Maryland   |  |
| 10a. State  |  | 10b. County   |                                | 10c. City, Town or Location  |  |  | 10d. Inside City Limits   |  |  |
| MD.   |  | Baltimore   |                                | Timonium   |  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number  |  | 10f. Zip Code   |                                |  | 10g. Citizen of What Country?                          |  |   |  |  |
| 12300 Rosslyn Ridge Rd. #506  |  | 21093   |                                |  | USA  |  |   |  |  |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |  | 14. Race - American Indian, Black, White, etc.                          |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |  | Specify: White  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                |  | 16b. Kind of Business Industry                         |  |   |  |  |
| Elementary/Secondary (0-12)   |  | College (1-4 or 5+)<br>5+   |                                |  | Educator   |  |   | Education  |  |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |  |  |  |   |  |  |
| John Patrick Reddington   |  | Margaret Shray  |                                |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |  |  |   |  |  |
| Mr. Tim Connor/ Nephew  |  | 1114 Hampton Garth Towson, MD. 21286  |                                |  |  |  |   |  |  |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                |  | Date   |  |   | 20c. Location - City or Town, State  |  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment  |  | Dulaney Valley Mem Gdns.  |                                |  | 5-15-12  |  |   | Timonium, MD.  |  |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |  |  |  |   |  |  |
|   |  | Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, MD. 21204   |                                |  |  |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  | 23b. Approximate Interval Between Onset and Death   |                                |  |  |  |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  | 23c. Due to (or as a consequence of):<br><br><i>Debility</i>  |                                |  |  |  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23d. Due to (or as a consequence of):   |                                |  |  |  |   |  |  |
| {   |  | 23e. Due to (or as a consequence of):   |                                |  |  |  |   |  |  |
| 23f. IF FEMALE:   |  | 23g. Due to (or as a consequence of):   |                                |  |  |  |   |  |  |
| 23h. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23i. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |                                |  | 23j. Date of delivery<br>Month Day Year                |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)   |                                |  | 23k. Did tobacco use contribute to the cause of death? |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |                                |  | 28b. Time of injury<br>M                               | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D 58303  |                                |  | 29d. Date signed (Month, Day, Year)<br>MAY 11 2012     |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |                                |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012  |  | 32. Registrar's Signature<br><i>James D. Parker</i>   |                                |  |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15pm  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15226

1 - For  
State  
Registrar

|                                     |  |   |  |   |   |  |   |  |
|-------------------------------------|--|---|--|---|---|--|---|--|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Albert Allen</b>  |  |   |   | 2. Date of Death<br>Month <b>04</b> Day <b>27</b> Year <b>12</b>             | 3. Time of Death<br><b>12:29 PM</b>                                     |  |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br><b>Union Hospital</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Elkton, MD</b>                    |   | 4c. County of Death<br><b>Cecil</b>  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br><b>218-32-6374</b>   | 6. Sex<br><b>1 X M 2 □ F</b>   | 7. Age (In yrs. last birthday)<br><b>75 Yrs.</b>  | If Under 1 Year<br>Months<br><b>0</b>                             | If Under 24 Hrs.<br>Days<br><b>0</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6/28/1936</b>              | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|                                     |  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Cecil</b>  |  |   |   | 10c. City, Town or Location<br><b>Chesapeake City</b>                        |   | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>   |
|                                     |  | 10e. Street and Number<br><b>220 Biddle Street</b>  |  |   |   | 10f. Zip Code<br><b>21915</b>  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|                                     |  | 11. Marital Status<br><b>1 X Never Married 2 □ Married<br/>3 □ Widowed 4 □ Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No<br/>If Yes, Give Year or Dates.</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b> |   |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b>   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |   |   | 16b. Kind of Business Industry<br><b>Plumbing/A.C.</b>                       |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Henry Allen</b>  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Ohrel</b>  |   |   |  |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ethel Snider - sister</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>160 Mac Cauley Road, Conowingo, MD 21918</b>                       |   |   |  |   |  |
|                                     |  | 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>   | Date<br><b>5/1/2012</b>   | 20c. Location - City or Town, State<br><b>Chesapeake City, MD</b> |  |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Richard J. Goofie</b>   | 22. Name and Address of Facility R.T. Foard Funeral Home, P.A.<br><b>259 E. Main Street, Elkton, MD 21921</b>  |   |   |  |   |  |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |   | Approximate Interval Between Onset and Death<br><b>Cerebrovascular accident</b>                          |
|                                     |  | <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |  |   |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 X No<br/>9 □ Unknown</b>  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b> | 23d. Date of delivery<br>Month Day Year   |   |  |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b> |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>       |   |   |  |   |  |
|                                     |  | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide 4 □ Homicide</b>   | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>                     | 28d. Describe how injury occurred  |   |  |
|                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
|                                     |  | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |   |  |   |  |
|                                     |  | 29b. Signature and title of certifier<br><b>MD</b>  | 29c. License number<br><b>D0062190</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/27/12</b>             |  |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHAHNAWAZ KHAN<br/>2533 AUGUSTINE HERMAN Hwy, SUITE A, CHESAPEAKE CITY, MD 21915,</b>  |  |   |   |  |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   | 32. Registrar's Signature<br><b>Laura A. Foard</b>   |   |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

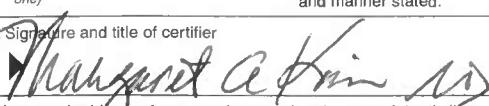
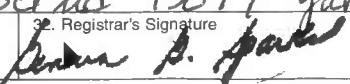
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15227

1 - For  
State  
Registrar

|                                     |  |  |   |   |  |   |  |   |   |  |  |   |  |  |
|-------------------------------------|--|--|---|---|--|---|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Linda Gray Adams</b>  |  |   |   |  | 2. Date of Death<br>Month<br>04   | Day<br>27  | Year<br>2012                                | 3. Time of Death<br>9:30 AM   |  |  |   |  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>430 Lemley Drive</b>  |  |   |   |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>                                  |  |   | 4c. County of Death<br><b>Garrett</b>   |  |  |   |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>217-44-7425</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65 Yrs.</b>  | If Under 1 Year<br>Months<br>If Under 24 Hrs.<br>Hours<br>Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>06/12/1946</b>                  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                   |  |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  | 10b. County<br><b>Garrett</b>   | 10c. City, Town or Location<br><b>Oakland</b>   |  |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        |  |  |   |  |  |
|                                     | 10e. Street and Number<br><b>430 Lemley Drive</b>  |  |   |   | 10f. Zip Code<br><b>21550</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b> |   |  |  |   |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>15. Decedent's Education<br/>(Specify only highest grade completed)</b><br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b><br><b>3</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>cirrhosis</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |   |  |  |   |  |  |
|                                     | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |  | <b>Systems Manager</b>  |   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                |  |   |   |  |  |   |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Lester Dewey Gray</b>  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gwynnola Genevieve Thompson</b> |  |   |   |  |  |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald C. Adams / Husband</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>430 Lemley Drive, Oakland, MD 21550</b>   |  |   |  |   |   |  |  |   |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>  |   |  | Date<br><b>Unknown</b>  | 20c. Location - City or Town, State<br><b>Arlington, VA</b>                |   |   |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550</b>  |   |  |   |  |   |   |  |  |   |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |   |   | Approximate Interval Between Onset and Death<br><b>6 mo</b>  |  |   |  |  |
|                                     | <p>a. <b>cirrhosis</b><br/>Due to (or as a consequence of):</p> <p>b. <b>autoimmune hepatitis</b><br/>Due to (or as a consequence of):</p> <p>c. <b>systemic lupus erythematosis</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |  |   |  |   |   |  |  |   |  |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown           |   |  |   |  |   | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>pulmonary hypertension, pancytopenia</b>  |  |   |   |  |   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)           |   |  |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day, Year)   |   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No        | 28d. Describe how injury occurred  |   |   |  |  |   |  |  |
|                                     |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |   |  |  |   |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                       |  |   |   |  |   |  |   |   |  |  |   |  |  |
|                                     | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 26650</b>   |   |  |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>4-27-2012</b>   |  |  |   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>margaret a kaisersud 13679 garrett highway oakland, md 21550</b>  |  |   |   |  |   |  |   |   |  |  |   |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be called at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15228

1- For State Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

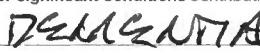
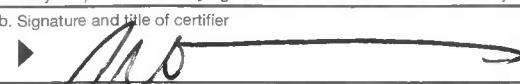
Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |             |   |                                |   |  |  |  |
|--|-------------|---|--------------------------------|---|--|--|--|
|  |             | 1. Decedent's Name (First, Middle, Last)  |                                | 2. Date of Death  |  | 3. Time of Death   |  |
|  |             | JEAN MARIE ARWOOD   |                                | MAY 1 2012  |  | 5:30A M  |  |
| 4a. Facility Name (if not institution, give street and number)   |             | 4b. City, Town, or Location of Death  |                                | 4c. County of Death   |  |  |  |
| 4678 LEONARDTOWN ROAD  |             | WALDORF   |                                | CHARLES   |  |  |  |
| 5. Social Security Number  |             | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)   | 9. Birthplace (State or Foreign Country) |
| 579-38-3670  |             | 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 81 Yrs.                        |   |  | SEP. 16, 1930  | WASH., DC                                |
| Usual Residence of Decedent  |             |   |                                |   |  |  |  |
| 10a. State   | 10b. County | 10c. City, Town or Location   |                                |   |  | 10d. Inside City Limits  |  |
| MD   | CHARLES     | WALDORF   |                                |   |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number   |             | 10f. Zip Code   |                                | 10g. Citizen of What Country?   |  |  |  |
| 4678 LEONARDTOWN ROAD  |             | 20601   |                                | U. S. A.  |  |  |  |
| 11. Marital Status   |             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |             |   |                                |   |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |             | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |                                | 16b. Kind of Business/Industry  |  |  |  |
| Elementary/Secondary (0-12) 12   |             | College (1-4 or 5+) ADMINISTRATIVE ASSISTANT  |                                | DC GENERAL HOSPITAL   |  |  |  |
| 17. Father's Name (First, Middle, Last)  |             |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)   |  |  |  |
| JAMES BERNARD GOLDSMITH  |             |   |                                | AGNES LORRAINE MIDDLETON  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |   |  |  |  |
| CYNTHIA BOWLING-DAUGHTER   |             | 4678 LEONARDTOWN ROAD WALDORF, MARYLAND 20601   |                                |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | MAY 4, 2012   | Date   | 20c. Location - City or Town, State  |  |
|  |             | MT. ZION CH.CEM.  |                                |   |  | MECHANICSVILLE, MD   |  |
| 21. Signature of Funeral Service Licensee  |             | 22. Name and Address of Facility  |                                | RAYMOND FUNL. SERVICE, P.A.   |  |  |  |
|   |             | M00641  |                                | 5635 WASHINGTON AVE., LA PLATA, MD 20646  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |             | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |                                | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
|  |             | { Due to (or as a consequence of):  |                                |   |  |  |  |
|  |             | b. Due to (or as a consequence of):   |                                |   |  |  |  |
|  |             | c. Due to (or as a consequence of):   |                                |   |  |  |  |
|  |             | d. Due to (or as a consequence of):   |                                |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |             | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                                | 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |    |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |             | 28a. Date of injury<br>(Month, Day, Year)   |                                | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             | 29c. License number   |                                | 29d. Date signed (Month, Day, Year)   |  |  |  |
|   |             | D 18545   |                                | MAY 1, 2012   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |             |   |                                |   |  |  |  |
| P. WISOTSKY M.D. 12070 OCELINE CENTER WALDORF, MD. 20602   |             |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)  |             | 32. Registrar's Signature   |                                |   |  |  |  |
| MAY 14 2012  |             |    |                                |   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15229

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

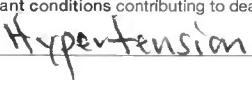
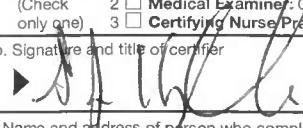
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Hour:Minute AM/PM  |
| Anna Rae BANZHOFF  |  | 4. Facility Name (if not institution, give street and number)<br>1515 Broadfording Road   |   | Hagerstown Washington  |
| 5. Social Security Number<br>214-28-0883   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>82 Yrs.   | 8. Date of Birth<br>(Month, Day, Year)<br>July 1, 1929   |
| 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10. Usual Residence of Decedent<br>Maryland Washington  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br>1515 Broadfording Road   |  | 10f. Zip Code<br>21740  |   | 10g. Citizen of What Country?<br>USA   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) 12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   | 16b. Kind of Business Industry<br>Her own home   |
| 17. Father's Name (First, Middle, Last)<br>William Edgar Gossard   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hazel Virginia McCardell   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert Banzhoff - Husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1515 Broadfording Road, Hagerstown, Md. 21740  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenlawn Mem. Park   | Date<br>5/3/2012  | 20c. Location - City or Town, State<br>Williamsport, Maryland                                  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Maryland 21740  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br>Renal Cell Carcinoma  |   |  |
| a. Due to (or as a consequence of):  |  |   |   |  |
| b. Due to (or as a consequence of):  |  |   |   |  |
| c. Due to (or as a consequence of):  |  |   |   |  |
| d. Due to (or as a consequence of):  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>Hypertension  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D0057285   |   | 29d. Date signed (Month, Day, Year)<br>4 30 2012   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G-J. Kobilall, 24 N. Walnut St. #102, Hagerstown, MD, 21740  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 01 2012   |  | 32. Registrar's Signature<br>  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15230

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|  |  |  |  |   |                          |   |  |   |
|--|--|--|--|---|--------------------------|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Iris C. Belt</b>  |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> Year <b>2012</b>   |                          |   |  | 3. Time of Death<br><b>8:10 a M</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>115 Metispa Drive</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Severna Park</b>   |                          |   |  | 4c. County of Death<br><b>Anne Arundel</b>  |
| 5. Social Security Number<br><b>216-68-8615</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (in yrs. last birthday)<br><b>56 Yrs.</b> | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept 23 1955</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>      |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Severna Park</b>  |                          |   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |
| 10e. Street and Number<br><b>115 Metispa Drive</b>   |  |  |  | 10f. Zip Code<br><b>21146</b>   |                          |   | 10g. Citizen of What Country?<br><b>USA</b>                      |   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b><br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |                          |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 2yrs Revenue Examiner</b> |  | 16b. Kind of Business/Industry<br><b>Maryland State Income Tax</b>  |                          |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Horace Sedgwick</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marian Pack</b>   |                          |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Belt (Husband)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 Metispa Drive Severna Park, Md. 21146</b>   |                          |   |  |   |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bakemont Memorial Gardens</b>  |                          | Date<br><b>5-1-12</b>   | 20c. Location - City or Town, State<br><b>Davidsonville, Md.</b> |   |
| 21. Signature of Funeral Service Licensee<br><b>Larry H. Reese</b>   |  |  |  | 22. Name and Address of Facility<br><b>Wm. Reese &amp; Sons Mortuary, P.A.<br/>1922 Forest Dr. Annapolis, Md. 21401</b>   |                          |   |  |   |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |                                 |   |  |  |   |
|---|--|---|---------------------------------|---|--|--|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Breast Cancer</b>   |  | Approximate Interval Between Onset and Death<br><b>2 years</b>  |                                 |   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Brain metastases</b>   |  | <b>1 year</b>   |                                 |   |  |  |   |
| a. Due to (or as a consequence of):<br><b>Brain metastases</b>  |  |   |                                 |   |  |  |   |
| b. Due to (or as a consequence of):   |  |   |                                 |   |  |  |   |
| c. Due to (or as a consequence of):   |  |   |                                 |   |  |  |   |
| d. _____  |  |   |                                 |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b><br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |                                 |   |  |  |   |
|   |  | 23d. Date of delivery<br>Month Day Year   |                                 |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                 |   |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |  |   |                                 |   |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |                                 |   |  |  |   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b><br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred  |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>J. Lee</b>  |                                 |   |  |  |   |
|   |  | 29c. License number<br><b>D54413</b>  |                                 |   | 29d. Date signed (Month, Day, Year)<br><b>Apr. 26, 2012</b>                  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Young J. Lee 3001 S. Hanover St. Baltimore MD 21225</b>  |  |   |                                 | 31. Date filed (Month, Day, Year)<br><b>APR 27 2012</b>                                     |  |  | 32. Registrar's Signature<br><b>Anne S. Parks</b> |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

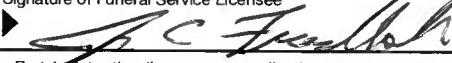
## Certificate of Death

2012 15231

Reg. No.

1 - For State Registrar

Physician/  
Medical  
Examiner

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 04 Day 27 Year 2012  |   | 3. Time of Death<br>5:25 AM  |  |
| Wesley Warren Blum   |  |  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>Oakland Nursing & Rehab Center   |  | 4b. City, Town, or Location of Death<br>Oakland  |   | 4c. County of Death<br>Garrett   |  |
| 5. Social Security Number<br>234-38-8247   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>84 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>03/01/1928                             |
| Usual Residence of Decedent<br>MD  |  | 10a. State<br>MD   |   | 10b. County<br>Garrett   |  |
| 10c. City, Town or Location<br>Swanton   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br>89 Swantamont Road   |  | 10f. Zip Code<br>21561   |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Mechanic   |   | 16b. Kind of Business/Industry<br>Self Employed  |  |
| 17. Father's Name (First, Middle, Last)<br>Warren Bryan Blum   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Stasha Justina Hawk   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Kevin Blum / Son   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>153 Blueberry Lane, Oakland, MD 21550   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrett County Memorial Gardens  |   | Date<br>4/30/2012  | 20c. Location - City or Town, State<br>Oakland, MD                               |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |  |   | Approximate Interval Between Onset and Death Years   |  |
| a. CAD sp MI<br>Due to (or as a consequence of):   |  |  |   |  |  |
| b. _____<br>Due to (or as a consequence of):   |  |  |   |  |  |
| c. _____<br>Due to (or as a consequence of):   |  |  |   |  |  |
| d. _____   |  |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hyper cholesterolemia  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |
| Chronic renal failure  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D15333  |   | 29d. Date signed (Month, Day, Year)<br>4/30/2012   |  |
| 29b. Signature and title of certifier<br>   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas G. Johnson 311 North Fourth Street Oakland, MD 21550  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 2012   |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15232

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| ROBERT LEWIS BYRAM                       | 04/24/2012                         | 0435a M          |

|  |                                      |                     |
|--|--------------------------------------|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| Holy Cross Hospital  | Silver Spring                        | Montgomery          |

Funeral  
Director

|                           |  |                                |                 |                  |  |  |
|---------------------------|--|--------------------------------|-----------------|------------------|--|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| 213-44-7471               | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 64 Yrs.                        | Months          | Days             | 12/19/1947                             | Washington, DC                           |

|            |             |                             |  |
|------------|-------------|-----------------------------|--|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| MD         | Montgomery  | Rockville                   |  |

|                        |               |                               |
|------------------------|---------------|-------------------------------|
| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| 13107 Hallet Court     | 20853         | USA                           |

|  |   |   |  |
|--|---|---|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|--|---|---|--|

|  |   |   |
|--|---|---|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Printing Company-Stripper | 16b. Kind of Business/Industry<br>Retail Printing |
|--|---|---|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| Robert E. Byram                         | dorothy DeLawder                                  |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Christina Byram/daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1803 Hanover Pike, #1, Hampstead, MD 21074 |
|--|---|

|   |  |      |  |
|---|--|------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Fort Lincoln Cemetery | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State<br>Brentwood, MD |
|---|--|------|--|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br>George R. French | 22. Name and Address of Facility<br>Snowden Funeral Home<br>246 N. Washington St., Rockville, MD 20850 |
|---|--|

|  |  |
|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |
| a. Respiratory failure<br>Due to (or as a consequence of):   |  |
| b. Pneumonia<br>Due to (or as a consequence of):   |  |
| c. Pulmonary Aspiration<br>Due to (or as a consequence of):  |  |
| d.   |  |

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|      |   |   |
|------|---|---|
| 23f. | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|------|---|---|

|   |   |   |
|---|---|---|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|---|---|

|   |   |                          |  |                                   |
|---|---|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury<br>(Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|---|---|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

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|--|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|--|

|   |                               |  |
|---|-------------------------------|--|
| 29b. Signature and title of certifier<br>Harold V. Lawson | 29c. License number<br>D67589 | 29d. Date signed (Month, Day, Year)<br>4/24/2012 |
|---|-------------------------------|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Harold V. Lawson, 1500 Forest Glen Road, Silver Spring, MD 20910 |
|--|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>MAY 01 2012 | 32. Registrar's Signature<br>Laura S. Park |
|--|--|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit B.

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15233

|   |  |  |  |  |   |  |   |  |  |                  |   |   |  |  |
|---|--|--|--|--|---|--|---|--|--|------------------|---|---|--|--|
| Physician/<br>Medical Examiner                |  | 1. Decedent's Name (First, Middle, Last)<br><b>Alex Bernard Baylor Jr.</b>   |  |  |   |  |   | 2. Date of Death<br>Month Day Year<br>April 23, 2012   |  |                  | 3. Time of Death<br>2300 hrs  |   |  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>Doctor's Community Hospital</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  |   | 4c. County of Death<br><b>Prince George's</b>  |  |                  |   |   |  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>578-08-7250</b>  |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>28 Yrs.</b>  |  | If Under 1 Year<br>Months<br><b>28</b>  | If Under 24 Hrs.<br>Days<br><b>0</b>   | Hours<br><b>0</b>  | Min.<br><b>0</b> | 8. Date of Birth (MM/DD/YYYY)<br><b>Nov. 27, 1983</b>   | 9. Birthplace (State or Foreign Country)<br><b>DC</b>   |  |  |
| To Be Completed by Funeral Director           |  | 10a. State<br><b>Maryland</b>  |  |  |   |  |   | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Springdale</b>                 |                  |   | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |
| To Be Completed by Funeral Director           |  | 10e. Street and Number<br><b>9213 Utica Place</b>  |  |  |   | 10f. Zip Code<br><b>20774</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>            |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify:<br><b>Black</b> |   |  | 14. Race - American Indian, Black, White, etc.                   |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 3</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>  |   |  | 16b. Kind of Business/Industry<br><b>Private</b>                 |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Alex B. Baylor Sr.</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Brenda D. Bates</b>  |   |  |  |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alex Baylor Sr. - Father</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9213 Utica Place Springdale, Maryland 20774</b>   |  |   |  |  |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery</b>   |  |   | Date<br><b>May 3, 2012</b>   | 20c. Location - City or Town, State<br><b>Landover, Maryland</b> |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart, Jr.</b>   |  |  | 22. Name and Address of Facility<br><b>M00560 4001 Benning Road NE Washington, DC 20019</b>   |  |   | Stewart Funeral Home, Inc.   |  |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><br>b. Coronary Artery Thrombosis<br>Due to (or as a consequence of):<br><br>c. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br><br>d.<br><br><b>□ UNPENDED □ AMENDED</b> |  |  |   |  |   |  |  |                  |   | Approximate Interval Between Onset and Death  |  |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b> |   |  | 23d. Date of delivery<br>Month Day Year |  |  |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  |  |                  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |  |   | 24a. Was an autopsy performed?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury  |   | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                      | 28d. Describe how injury occurred                                |                  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |  |  |   |  |   |  |  |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 29b. Signature and title of certifier<br><b>Alexander J. Stewart</b>   |  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 2012</b>     |                  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |  |   |  |   |  |  |                  |   |   |  |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>May 01 2012</b>  |  | 32. Registrar's Signature<br><b>Alexander J. Stewart</b>   |   |  |   |  |  |                  |   |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

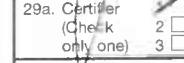
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15234

Reg. No.

1 For  
State  
Registrar

|   |  |   |   |  |   |   |   |  |   |   |  |
|---|--|---|---|--|---|---|---|--|---|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Karen Barnhart</b>  |   |   |  |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> Year <b>2012</b>  | 3. Time of Death<br><b>1548 M</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Meritus Medical Center</b>  |   |   |  |   |   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  | 4c. County of Death<br><b>Washington</b>  |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>220-54-3554</b>  |   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>62 Yrs.</b>   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>09/13/1949</b> | 9. Birthplace (State or Foreign Country)<br><b>Unknown</b>   |   |   |  |
|   | Usual Residence of Decedent<br><b>MD Washington</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Hagerstown</b>            |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |   |  |
| <b>To Be Completed by Funeral Director</b>  | 10e. Street and Number<br><b>703 Walnut Towers</b>   |   |   |  | 10f. Zip Code<br><b>21740</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
|   | 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b> |   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b> |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) Unknown</b>  |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b> |   |   | 16b. Kind of Business/Industry<br><b>Retail Sales</b>       |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Barnhart</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |   |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Barnhart, Jr./Nephew</b>  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14432 Tollgate Ridge Road Hancock, MD 21750</b>       |   |   |  |   |   |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                              |   |   | Date<br><b>04/25/2012</b>                                   | 20c. Location - City or Town, State<br><b>Smithsburg, MD</b>   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>141 West Main Street<br/>Grove Funeral Home, P.A. Hancock, MD 21750-0368</b>                |   |   |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |   |   |  |   |   |  |
| <p>a. Due to (or as a consequence of):<br/><b>Metastatic Cancer of ovary - months</b></p> <p>b. Due to (or as a consequence of):<br/><b>Diabetes Mellitus - years</b></p> <p>c. Due to (or as a consequence of):<br/><b>Chronic Kidney Disease - years</b></p> <p>d. _____</p>  |  |   |   |  |   |   |   |  |   |   |  |
| Approximate Interval Between Onset and Death  |  |   |   |  |   |   |   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>              |   |  |   |   |   |  | 23d. Date of delivery<br>Month Day Year   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumal Effusion</b>   |  |   |   |  |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
|   |  |   |   |  |   |   |   |  |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   |  |   |   |   |  |   |   |  |
| 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>May</b>   |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |   | 28d. Describe how injury occurred  |   |   |  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner</b>  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |   |  |   |   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Hagerstown, MD 21750</b>   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DOO45021</b>  |   |  |   |   |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>April 24 2012</b>   |  |
| 30. Name and address of person who committed cause of death (Item 23a) (Type, Print)<br><b>SHARON J. BARNHART 8107 Anheiser St Hagerstown MD 21740</b>  |  |   |   |  |   |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br>  |   |  |   |   |   |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4/14/2012

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15235

Reg. No.

1 - For  
State  
Registrar

|  |  |   |  |   |                           |   |  |   |  |  |
|--|--|---|--|---|---------------------------|---|--|---|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  |                           |   |  | 3. Time of Death  |  |  |
|  |  | Jo-Ann Carroll Bixler   |  | Month May 4 Day 2012 Year   |                           |   |  | 0945 A M  |  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                           |   |  | 4c. County of Death   |  |  |
|  |  | 24 Duck Hollow Drive  |  | Elkton  |                           |   |  | Cecil   |  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 5. Social Security Number   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.<br>71  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br>April 14, 1941 | 9. Birthplace (State or Foreign Country)<br>Delaware  |  |  |
| Funeral<br>Director  |  | 10a. State<br>Maryland  |  | 10b. County<br>Cecil  |                           | 10c. City, Town or Location<br>Elkton   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| To Be Completed by Funeral Director                                |  | 10e. Street and Number<br>24 Duck Hollow Drive  |  | 10f. Zip Code<br>21921  |                           |   |  | 10g. Citizen of What Country?<br>United States  |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Medical Assistant   |                           | 16b. Kind of Business Industry<br>Health Care   |  |   |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br>Charles W. Carroll, Sr.  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Henrietta Ganzmann  |                           |   |  |   |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br>William E. Bixler/Husband   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24 Duck Hollow Drive, Elkton, MD 21921   |                           |   |  |   |  |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of Cemetery, cemetery or other place)<br>Cherry Hill Methodist Cemetery   |                           | Date<br>May 9, 2012   | 20c. Location - City or Town, State<br>Cherry Hill, MD   |   |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br>► Joseph S. Shubs  |  | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton Street, Elkton, MD 21921   |                           |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br>CEREBROVASCULAR ACCIDENT   |                           |   |  | Approximate Interval Between Onset and Death  |  |  |
|  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. Due to (or as a consequence of):<br>URINARY TRACT INFECTION  |                           |   |  |   |  |  |
|  |  |   |  | 23d. Due to (or as a consequence of):<br>STAGE IV PRESSURE ULCER, SACRUM  |                           |   |  |   |  |  |
|  |  |   |  | 23e. Due to (or as a consequence of):<br>FAILURE TO THRIVE  |                           |   |  |   |  |  |
|  |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |                           |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                           |   |  |   |  |  |
|  |  |   |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                           |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                           |   |  |   |  |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                        |   |  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|  |  | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                           |   |  |   |  |  |
|  |  | 29b. Signature and title of certifier<br>► J. S. Shubs MD   |  | 29c. License number<br>D67466   |                           |   |  | 29d. Date signed (Month, Day, Year)<br>5/7/12   |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CORNELIUS OPE, MD 14 ROGERS RD SUITE 211 NORTH EAST, MD   |  |   |                           |   |  |   |  |  |
| State<br>Registrar   |  | 31. Date filed (Month, Day, Year)<br>MAY 14 2012  |  | 32. Registrar's Signature -<br>Joseph S. Shubs  |                           |   |  |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

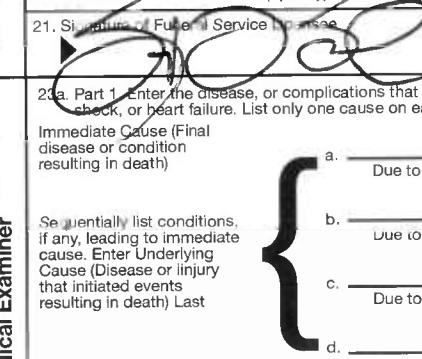
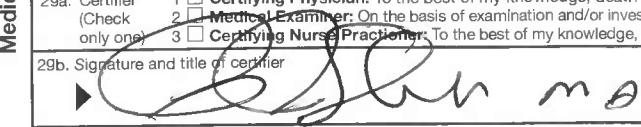
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15236

1 - For State Registrar

|  |   |   |   |   |   |   |  |  |  |
|--|---|---|---|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>PHYLLIS KINCAID BLACKISTON</b>   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>3</b> Year <b>2012</b>                                    | 3. Time of Death<br><b>8:36 pM</b>                                      |  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>12669 Scotts Lane</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Galena</b>   |   | 4c. County of Death<br><b>Kent</b>   |  |  |
| Funeral Director   | 5. Social Security Number<br><b>216-48-5398</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b><br>Yrs.   | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.                        | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept 4 1946</b>  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>        |  |  |  |
| To Be Completed by Funeral Director                                | 10a. State <b>MD</b> 10b. County <b>Kent</b> 10c. City, Town or Location <b>Galena</b> 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |   |  |  |  |
|  | 10e. Street and Number<br><b>12669 Scotts Lane</b>  |   |   | 10f. Zip Code<br><b>21635</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Health Aide</b>   |   |   | 16b. Kind of Business Industry<br><b>Home Health Care</b>               |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Cleamon M. Kincaid</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Evans</b>                                |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark Blackiston (son)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12669 Scotts Lane Galena, MD. 21635</b> |   |   |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crumpton Cemetery</b>  |   | Date<br><b>5/8/12</b>   | 20c. Location - City or Town, State<br><b>Crumpton, MD.</b>             |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Operator<br>   |   | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen L. Schaech<br/>118 West Cross St. Galena, MD. 21635</b>   |   |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End Stage Cirrhosis</b>  |   |   |   |   |   | Approximate Interval Between Onset and Death<br><b>&gt;3 yr</b>  |  |  |
|  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____   |   |   |   |   |   |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year                                 |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      | 28d. Describe how injury occurred                                       |  |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |   |  |  |  |
|  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>DD0310054</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>5-4-12</b>                    |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |   | 32. Registrar's signature<br>  |   |   |   |  |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

*5/14/12*

To the Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15237

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)

Robert Warren Cline, II

2. Date of Death

Month Day Year  
April 25, 2012

3. Time of Death

23:37 p<sup>M</sup>

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|   |   |  |  |   |      |  |  |
|---|---|--|--|---|------|--|--|
| 4a. Facility Name (if not institution, give street and number)  |   |  | 4b. City, Town, or Location of Death   |   |      | 4c. County of Death  |  |
| 653 Oak Hill Avenue   |   |  | Hagerstown   |   |      | Washington   |  |
| 5. Social Security Number<br><b>214-46-5960</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours   | Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug. 28, 1953</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>        |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Washington</b>  | 10c. City, Town or Location<br><b>Hagerstown</b> |  |   |      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>653 Oak Hill Avenue</b>  |   |  | 10f. Zip Code<br><b>21740</b>  |   |      | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Tax Accountant</b>  |   |      | 16b. Kind of Business/Industry<br><b>Finance</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Warren Cline, Sr.</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Mercereau</b> |      |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerry W. Mathery / Partner</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>653 Oak Hill Avenue, Hagerstown, MD 21740</b>  |   |      |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Rhea M. Mitts</b> |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |   |      | Date<br><b>5/1/2012</b>  | 20c. Location - City or Town, State<br><b>Smithsburg, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br><b>Rhea M. Mitts</b>   |   |  | 22. Name and Address of Facility<br><b>Rest Haven Funeral Chapel<br/>1601 Pennsylvania Ave., Hagerstown, MD 21742</b>  |   |      |  |  |

|  |  |   |  |  |
|--|--|---|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | 23b. Due to (or as a consequence of):<br><b>Acute Myocardial Infarction</b> |  | Approximate Interval Between Onset and Death<br><b>minutes</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><b>Coronary Artery Disease</b>     |  | <b>years</b>   |
| {  |  | 23d. Due to (or as a consequence of):<br><b>Chronic Respiratory Failure</b> |  | <b>years</b>   |
| d.   |  | 23e. Due to (or as a consequence of):<br><b>Restrictive Lung Disease</b>    |  | <b>years</b>   |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |  |  |  |
|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Mitochondrial Disease</b> |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |

|  |   |                          |  |  |
|--|---|--------------------------|--|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                          |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |
|--|
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|--|

|  |   |   |
|--|---|---|
| 29b. Signature and title of certifier<br><b>Karen Jill Ciccarelli</b>  | 29c. License number<br><b>MDC052136</b> | 29d. Date signed (Month, Day, Year)<br><b>4/27/2012</b> |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Karen Jill Ciccarelli 16605 Kindle Rd Williamsport MD 21795</b> |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  | 32. Registrar's Signature<br>           |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15238

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |   |  |
|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ida Orie Churchey</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>2</b> Year <b>2012</b>  | 3. Time of Death<br><b>7:40 a M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>17607 Oak Ridge Drive</b>   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   | 4c. County of Death<br><b>Washington</b>   |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>569-40-6141</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |
|  | If Under 1 Year<br>Months      Days  |   | If Under 24 Hrs.<br>Hours      Min.  |
|  |  |   |  |
|  |  |   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 11, 1933</b>   |
|  |  |   | 9. Birthplace (State or Foreign Country)<br><b>Colorado</b>  |
| <b>To Be Completed by Funeral Director</b>   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Washington</b>  | 10c. City, Town or Location<br><b>Hagerstown</b>   |
|  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>17607 Oak Ridge Drive</b>   |   | 10f. Zip Code<br><b>21740</b>  |
|  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>9</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      Specify: <b>Mexican</b> |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |
|  |  |   | 16b. Kind of Business/Industry<br><b>Home</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Jose Sena</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eufemia Sanchez</b>  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judy Rima (Daughter)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5510 Beulah Road North Chesterfield, VA 23237</b>  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Bette Osh</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>  |
|  |  |   | Date <b>May 3, 2012</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bette Osh</b>  |   | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |
|  | 22. Name and Address of Facility<br><b>Osborne Funeral Home P.A.<br/>425 S. Conococheague St. Williamsport, MD 21795</b>   |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b> |   |  |
|  | Approximate Interval Between Onset and Death<br><b>6 MONTHS</b>  |   |  |
|  | a. Due to (or as a consequence of):<br><b>LUNG CANCER</b>  |   |  |
|  | b. Due to (or as a consequence of):  |   |  |
|  | c. Due to (or as a consequence of):  |   |  |
|  | d. _____   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown        |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                   |
|  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)        |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |
|  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br><b>D53634</b>   |   |  |
| 29b. Signature and title of certifier<br><b>MATT BECKWITH</b>  | 29d. Date signed (Month, Day, Year)<br><b>May 3, 2012</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MATT BECKWITH</b>   | 31. Date filed (Month, Day, Year)<br><b>MAY 8 2012</b>   |   |  |
|  | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15239

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Lillian Gail Cook

2. Date of Death

Month

Day

Year

3. Time of Death

8:37 P M

4a. Facility Name (if not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

217-64-7827

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 9, 1954

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State Maryland

10b. County Charles

10c. City, Town or Location Waldorf

10d. Inside City Limits  Yes 2  No

permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10e. Street and Number

3212 Bethesda Drive

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Seconday (0-12) 12th.

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Hair Stylist

16b. Kind of Business Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Robert Harrison Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Vidotto

19a. Informant's Name/Relationship (Type, Print)

Gary Cook/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3212 Bethesda Drive, Waldorf, Maryland 20601

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Heritage Mem. Cem.

Date

May 4, 2012

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Kelli N Brown MO1190

22. Name and Address of Facility

Huntt Funeral Home

3035 Old Washington Rd. Waldorf, MD. 20601

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
severe sepsis

b. Due to (or as a consequence of):  
pneumonia

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DCA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury

(Month, Day, Year)

M

28b. Time of injury

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Brown

29c. License number

D37174

29d. Date signed (Month, Day, Year)

4/28/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONG YOUNG M.D. 7C Post Office Road, Waldorf, MD 20602

31. Date filed (Month, Day, Year)

MAY 01 2012

32. Registrar's Signature

Suzanne S. Parker

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15240

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

|   |  |  |   |  |
|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>4:15 PM  |
| Sybil Dean Caparratto   |  | April 28 2012  |   |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death   |   | 4c. County of Death  |
| 45 Walton Road  |  | Huntingtown  |   | Calvert  |
| 5. Social Security Number<br>577-26-8249<br>Usual Residence of Decedent   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>88 Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br>09-21-1923  |
| 10a. State<br>MD  |  | 10b. County<br>Calvert   |   | 10c. City, Town or Location<br>Huntingtown   |
| 10e. Street and Number<br>45 Walton Road  |  | 10f. Zip Code<br>20639   |   | 10g. Citizen of What Country?<br>USA   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>2   |   | 16b. Kind of Business/Industry<br>Homemaker<br>Own Home  |
| 17. Father's Name (First, Middle, Last)<br>Charles Franklin Jones   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Florence Atchley   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ralph K. Caparratto, Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3700 27th Street, Chesapeake Beach, MD 20732  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |   | Date<br>20c. Location - City or Town, State<br>05-03-2012 Alexandria, VA   |
| 21. Signature of Funeral Service Licensee<br>► William H. Weigel  |  | 22. Name and Address of Facility<br>Rausch Funeral Home, P.A.<br>8325 Mt. Harmony Lane, Owings, MD 20736   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Approximate Interval Between Onset and Death<br>Y YEARS                                       |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | a. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):   |   |  |
|   |  | b. _____<br>Due to (or as a consequence of):   |   |  |
|   |  | c. _____<br>Due to (or as a consequence of):   |   |  |
|   |  | d. _____   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION, HYPERTENSION   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D26358  |   | 29d. Date signed (Month, Day, Year)<br>APRIL 30 2012   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>John H. WEIGEL, MD - PRINCE FREDERICK, MD - 20678   |  | 32. Registrar's Signature<br>Deanne B. Spates  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 2012  |  | 32. Registrar's Signature<br>Deanne B. Spates  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 1524

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

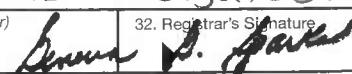
Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20pm

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anna Chaky</b>   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>08</b> Year <b>2012</b>   | 3. Time of Death<br>7:11 PM                                  |
| 4a. Facility Name (if not institution, give street and number)<br><b>3873 Colwyn Drive</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Jarrettsville, MD</b>  |  |
| 4c. County of Death<br><b>Harford</b>   |  |  |  |   |  |
| 5. Social Security Number<br><b>158-16-0579</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>85 Yrs.</b> | If Under 1 Year<br>Months      Days      Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 3, 1926</b> |
| Usual Residence of Decedent<br><b>MD</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Jarrettsville, MD</b>   |  |
| 10a. State<br><b>MD</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>3873 Colwyn Drive</b>  |  |  |  | 10f. Zip Code<br><b>21084</b>   | 10g. Citizen of What Country?<br><b>USA</b>                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Domestic</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Librizzzi</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Emil Chaky</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3873 Colwyn Drive, Jarrettsville, MD 21084</b>  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Cremation Direct Service</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MAY 1, 2012</b>   |  | Date  | 20c. Location - City or Town, State<br><b>York, PA</b>       |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Burg Funeral Home, Inc., 134 W. Broadway, Red Lion</b>  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |   |  |
| <p>a. <u>Pneumonia</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Cerebrovascular Accident</u>.<br/>Due to (or as a consequence of):</p> <p>c. <u>Hypertension</u><br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>Dementia, Hypercholesterolemia</u><br><u>and Vitamin D deficiency</u>  |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                            |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D0059387</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/30/2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Aly Naguib 2 Colgate Dr. Suite 103 Forest Hill, MD 21050</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>   |  | 32. Registrar's Signature<br>   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15242

1- For  
State  
Registrar

|                                     |  |   |   |   |                          |  |  |  |   |
|-------------------------------------|--|---|---|---|--------------------------|--|--|--|---|
| Physician /Medical Examiner         | 1. Decedent's Name (First, Middle, Last)<br><b>Joyce Audrey Denny</b>  |   |   |   |                          |  |  | 2. Date of Death<br>Month Day Year<br><b>April 25 2012</b>   | 3. Time of Death<br><b>12:29 PM</b>   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Civista Medical Center</b>  |   |   | 4b. City, Town, or Location of Death<br><b>LAPLATA, MD</b>  |                          | 4c. County of Death<br><b>Charles</b>  |  |  |   |
| Funeral Director                    | 5. Social Security Number<br><b>579-24-1772</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b><br>Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 9, 1925</b>                | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |  |   |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State<br><b>MD.</b> 10b. County<br><b>Charles</b> 10c. City, Town or Location<br><b>Waldorf</b>  |   |   |   |                          |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>X</b>   |   |
|                                     | 10e. Street and Number<br><b>70 Village Street Apt. 401</b>  |   |   | 10f. Zip Code<br><b>20602</b>   |                          |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1945-1950</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b>   |                          |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  |   |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Home Maker</b>                 |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |                          |  |  |  |   |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Harvey Reed McConnell Sr.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Audrey Hiles McFarland</b>  |                          |  |  |  |   |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Diana Hancock (Daughter)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16301 Sharpersville Rd. Waldorf, MD. 20601</b>  |                          |  |  |  |   |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Huntt Crematory</b>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Huntt Crematory</b>  |                          |  | Date<br><b>April 27, 2012</b>  |  |   |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Kelli N Brum m01190</b>  |   |   | 20c. Location - City or Town, State<br><b>Waldorf, MD.</b>  |                          |  |  |  |   |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acute Renal Failure</b>   |   |   |   |                          |  |  | Approximate Interval Between Onset and Death   |   |
|                                     | a. Due to (or as a consequence of):<br><b>Hypercalcemia</b>  |   |   |   |                          |  |  |  |   |
|                                     | b. Due to (or as a consequence of):<br><b>Hypercalcemia</b>  |   |   |   |                          |  |  |  |   |
|                                     | c. Due to (or as a consequence of):  |   |   |   |                          |  |  |  |   |
|                                     | d. Due to (or as a consequence of):  |   |   |   |                          |  |  |  |   |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |                          |  | 23d. Date of delivery<br>Month Day Year  |  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                          |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     |  |   |   |   |                          |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |                          |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   |   | 28a. Date of Injury<br>(Month, Day Year)  |                          | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                              | 28d. Describe how injury occurred  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   | 29c. License number<br><b>D-0066864</b>   |                          |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 2012</b>   |  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Richard Ferraro MD 5 Garrett Ave La Plata, MD 20646</b>   |   |   |   |                          |  |  |  |   |
|                                     |  |   |   |   |                          |  |  |  |   |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |   |   | 32. Registrar's Signature<br><b>Anne P. Parker</b>  |                          |  |  |  |   |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15243

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036  
 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Russell DeVaughn</b>                              |  |   | 2. Date of Death<br>Month April Day 27 Year 2012  | 3. Time of Death<br>4:45 PM  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Calvert County Nursing Center</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  |
| 5. Social Security Number<br><b>578-42-3716</b>  |  |   | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>82 Yrs.</b>   |
| 8. If Under 1 Year<br>Months   |  |   | If Under 24 Hrs.<br>Days  | 9. Date of Birth<br>(Month, Day, Year)<br><b>07-30-1929</b>  |
| 10a. State<br><b>MD</b>  |  |   | 10b. County<br><b>Calvert</b>   |  |
| 10c. City, Town or Location<br><b>Owings</b>   |  |   | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>  |  |
| 10e. Street and Number<br><b>110 West Mt. Harmony Road</b>   |  |   | 10f. Zip Code<br><b>20736</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |   |   |  |
| 11. Marital Status<br><b>1 □ Never Married 2 X Married</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No</b><br>If Yes, Give Year or Dates.<br><b>1951-52</b>                   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><b>1 □ Yes 2 X No Specify:</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Purchasing Agent</b> |   | 16b. Kind of Business/Industry<br><b>Maryland State Highway Administration</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Joseph DeVaughn</b>                                |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Virginia Richards</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marvin R. DeVaughn, Son</b>                       |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2610 Hannon Court, Owings, MD 20736</b> |  |
| 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State</b>                     |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                     | Date<br><b>04-28-12</b>  |
| 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>William R. Gruen</b>                                     |  |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.</b>  |  |
|  |  |   | 8325 Mt. Harmony Lane, Owings, MD 20736   |  |

|  |  |  |   |                                   |
|--|--|--|---|-----------------------------------|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |  | Approximate Interval Between Onset and Death  |                                   |
| <p>a. <u>Atherosclerotic Cardiovascular disease</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Hypertensive Heart disease</u><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |  |   |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No 9 □ Unknown</b>   |  |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify) _____<br>9 □ Unknown |                                   |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End stage dementia</b><br><b>Renal insufficiency</b><br><b>Congestive heart failure</b>   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown   |                                   |
| 23f. Was case referred to medical examiner?<br>1 □ Yes 2 X No  |  |  | 23g. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 X No   |                                   |
| Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ D.O.A. Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)   |  |  |   |                                   |
| 26. Place of Death (Check only one)  |  |  |   |                                   |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  |  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M          |
|  |  |  | 28c. Injury at work?<br>1 □ Yes 2 □ No  | 28d. Describe how injury occurred |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                   |
|  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                   |
| 29a. Certifier<br>(Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                                   |
| 29b. Signature and title of certifier<br><b>Gyan C. Surana</b>   |  |  | 29c. License number<br><b>D-50653</b>   |                                   |
|  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4-27-2012</b>   |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5851 Deale Churchton Road Deale MD 20757</b>  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |                                   |
|  |  |  | 32. Registrar's Signature<br><b>Gyan C. Surana</b>  |                                   |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

State  
Registrar

ORIGINAL

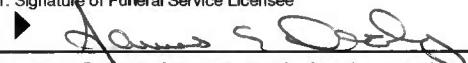
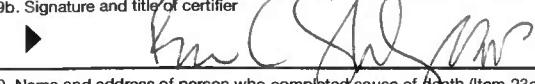
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15244

1 - For  
State  
Registrar

|  |  |   |  |   |  |   |  |  |  |   |
|--|--|---|--|---|--|---|--|--|--|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Doris May Di Silvestre</b>  |   |  |   |  |   |  | 2. Date of Death<br>Month April Day 27 Year 2012   | 3. Time of Death<br>2:30 a.m.                |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Vantage House Health Care Ctr.</b>  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |  |   | 4c. County of Death<br><b>Howard</b>   |  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-34-0751</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83 Yrs.</b> | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 14, 1928</b> | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                              |  |  |   |
|  | Usual Residence of Decedent<br><b>MD Howard</b>  |   |  | 10c. City, Town or Location<br><b>Columbia</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |
| 10e. Street and Number<br><b>5400 Vantage Point Road</b>   |  |   |  | 10f. Zip Code<br><b>21044</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b><br>Specify:                     |  |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |   |  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Frederick Deffer</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Lorraine Brooke</b>  |  |   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Diane Harper/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2358 Riverside Avenue, #503, Jacksonville, FL 32204</b>                                     |  |   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | Date<br><b>May 2, 2012</b>  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>                      |   |  |  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd. W, Silver Spring, MD 20901</b>   |  |   |  |   |  |  |  |   |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |   |  |  | Approximate Interval Between Onset and Death |   |
|  | <p>a. <b>Liver Malignancy- Primary Source Unknown</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Coronary Artery Disease</b><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |   |  |   |  |   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____                                     |  |   |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |   |  |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                             |  |  |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Nurse Practitioner  |  | 29b. Signature and title of certifier<br>  |  |   |  |   |  |  | 29c. License number<br><b>R137750</b>        | 29d. Date signed (Month, Day, Year)<br><b>4/27/12</b> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brian Sharkey, CRNP 6334 Cedar Lane, #103, Columbia, MD 21044</b>   |  |   |  |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br>  |  |   |  |   |  |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit B

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

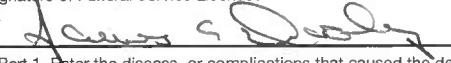
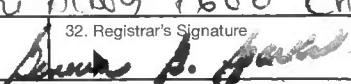
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15245

1 - For  
State  
Registrar

|                                     |  |   |   |   |  |   |  |   |
|-------------------------------------|--|---|---|---|--|---|--|---|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last) <b>MARGARET E. DURBIN</b>  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>29</b> Year <b>2012</b>   | 3. Time of Death<br><b>18:05 M</b>                       |   |  |   |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>  |   | 4b. City, Town, or Location of Death<br><b>TAKOMA PARK</b>  |  |   |  |   |
| To Be Completed by Funeral Director |  | 4c. County of Death<br><b>MONTGOMERY</b>  |   |   |  |   |  |   |
|                                     |  | 5. Social Security Number<br><b>204-22-8706</b>   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>94</b><br>Yrs.   | If Under 1 Year<br>Months      Days      Hours      Min. |   |  |   |
|                                     |  | Usual Residence of Decedent<br><b>MD Montgomery</b>   |   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct. 20, 1917</b>  |  |   |  |   |
|                                     |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |
|                                     |  | 10e. Street and Number<br><b>8505 Springvale Road, #259</b>   |   | 10f. Zip Code<br><b>20910</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |
|                                     |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>          |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b><br>Specify:                                |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>   |  | 16b. Kind of Business/Industry<br><b>Upholstery</b>   |  |   |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Herman Wischnewski</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Leide</b>  |  |   |  |   |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Diana L. Lautenberger/Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>800 Rowen Road, Silver Spring, MD 20910</b>   |  |   |  |   |
|                                     |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>May 1, 2012</b>  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b> |   |
|                                     |  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd. W., Silver Spring, MD 20901</b>  |  |   |  |   |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CONGESTIVE HEART FAILURE</b>   |   |   |  | Approximate Interval Between Onset and Death  |  |   |
|                                     |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>FAILURE TO THRIVE</b>  |   |   |  |   |  |   |
|                                     |  | a. Due to (or as a consequence of):<br><b>CONGESTIVE HEART FAILURE</b>  |   |   |  |   |  |   |
|                                     |  | b. Due to (or as a consequence of):<br><b>FAILURE TO THRIVE</b>   |   |   |  |   |  |   |
|                                     |  | c. Due to (or as a consequence of):<br><b></b>  |   |   |  |   |  |   |
|                                     |  | d. _____  |   |   |  |   |  |   |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b>      |  | 23d. Date of delivery<br>Month Day Year   |  |   |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b> |  |   |
|                                     |  |   |   |   |  |   |  |   |
|                                     |  |   |   |   |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |   |
|                                     |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |   |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   | 26. Place of Death (Check only one)<br><b>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |   |  |   |
|                                     |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                                 | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   | 28d. Describe how injury occurred                            |   |
|                                     |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
|                                     |  | 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |   |  |   |  |   |
|                                     |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>DO69051</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 30TH 2012</b>   |  |   |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BERNICE KUREK AKA 7600 CARROLL AVENUE, TAKOMA PARK, MD 20912</b>   |   |   |  |   |  |   |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |   | 32. Registrar's Signature<br>  |  |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 25 per me, g927, 05/25/2012dbs  
State Registrar

Certificate of Death

Reg. No.

2012 15246

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director  
  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
  
Fax to ME: 301-574-2036

Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |   |
|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>11:40AM   |
| Eugene Francis ELLIOTT   |  | April 30, 2012   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><br>Meritus Medical Center   |  | 4b. City, Town, or Location of Death<br><br>Hagerstown   |   | 4c. County of Death<br><br>Washington   |
| 5. Social Security Number<br>159-20-0839   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>84 Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br>June 25 1927   |
| Usual Residence of Decedent<br><br>Maryland Washington   |  | 10c. City, Town or Location<br><br>Hagerstown  |   | 9. Birthplace (State or Foreign Country)<br><br>Pennsylvania  |
| 10a. State<br>Maryland   |  | 10b. County<br>Washington  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 10e. Street and Number<br>35 Avalon Avenue   |  | 10f. Zip Code<br>21740   |   | 10g. Citizen of What Country?<br>USA  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1959-72  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>X |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) 4  |   | 16b. Kind of Business/Industry<br>Truck Driver  |
| 17. Father's Name (First, Middle, Last)<br>Francis Charles Elliott   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jennie Viola Teague   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Richard Elliott - Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>35 Avalon Avenue, Hagerstown, Maryland 21740  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenlawn Mem. Park  |   | Date 5/5/2012   |
| 20c. Location - City or Town, State<br>Williamsport, Maryland  |  |  |   |   |
| 21. Signature of Funeral Service Licensee<br><br>SCOTT M. DUNN   |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Maryland 21740   |   |   |
| 23a. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Acute intracranial Haemorrhage   |   | Approximate Interval Between Onset and Death  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D70607  |   | 29d. Date signed (Month, Day, Year)<br>4/30/2012  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>Ramesh Kumar, MD 11116 Medical Campus Rd. Hagerstown, MD 21742   |  | 31. Date filed (Month, Day, Year)<br>APR 09 2012   |   | 32. Registrar's Signature   |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15247

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |   |   |   |  |   |  |  |
|--|---|---|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month Day Year  |   |  |   | 3. Time of Death   |  |
| Lois Elizabeth Eardley   |   | May 2, 2012   |   |  |   | 1:05 a <sup>M</sup>  |  |
| 4a. Facility Name (if not institution, give street and number)   |   | 4b. City, Town, or Location of Death  |   |  |   | 4c. County of Death  |  |
| Williamsport Nursing Home  |   | Williamsport  |   |  |   | Washington   |  |
| 5. Social Security Number  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                                   | 8. Date of Birth<br>(Month, Day, Year)<br>July 27, 1931  | 9. Birthplace (State or Foreign Country)<br>Maryland |
| 220-26-7209  |   |   |   |  |   |  |  |
| Usual Residence of Decedent  |   |   |   |  |   |  |  |
| 10a. State<br>MD   | 10b. County<br>Washington   | 10c. City, Town or Location<br>Hagerstown   |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>11214 Greenberry Road  |   | 10f. Zip Code<br>21740  |   |  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   |  |   | 16b. Kind of Business Industry<br>Domestic   |  |
| 17. Father's Name (First, Middle, Last)<br>William Franklin Bailey   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lena Irene Semler           |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Russell C. Eardley / Spouse  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11214 Greenberry Road, Hagerstown, MD 21740  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |   | Date<br>5/7/2012   | 20c. Location - City or Town, State<br>Hagerstown, Maryland |  |  |
| 21. Signature of Funeral Service Licensee<br>► J. Mark Sayp  |   | 22. Name and Address of Facility<br>Rest Haven Funeral Chapel<br>1601 Pennsylvania Ave., Hagerstown, MD 21742   |   |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |   |  |  |
| <p>a. <i>Ischemic Cardiomyopathy</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Coronary artery disease</i><br/>Due to (or as a consequence of):</p> <p>c. <i>Hypertension</i><br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |   |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of Injury<br>M                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                           |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br>D0063833   |   |  |   |  |  |
| 29b. Signature and title of certifier<br>► Shahid Mahmood MD   |   | 29d. Date signed (Month, Day, Year)<br>05/02/2012   |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Shahid Mahmood 580C Northeen Ave Hagerstown MD 21742   |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |   | 32. Registrar's Signature<br>Suzanne S. Parker  |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15248

|                                     |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |
|-------------------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1- For State Registrar              |  | Decedent's Name (First, Middle, Last)<br><b>TALLY FORD, Sr.</b>  |  |   |  |   |  |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>25</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>1:40 P.M.</b>   |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>313 Rollins Ave</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Capitol Heights,</b>   |  |  |  | 4c. County of Death<br><b>Prince George's</b>   |  |  |  |   |  |  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>214-54-0890</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75 Yrs.</b>  |  | If Under 1 Year<br>Months <b></b> Days <b></b>   |  | If Under 24 Hrs.<br>Hours <b></b> Min. <b></b>  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 9, 1936</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>   |  |  |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Capitol Heights,</b>  |  |  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |  |
|                                     |  | 10e. Street and Number<br><b>313 Rollins Ave</b>   |  |   |  | 10f. Zip Code<br><b>20743</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |   |  |  |  |
|                                     |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1954-1957</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>XX</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |  |  |   |  |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Plumber</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Plumbing</b>   |  |  |  |   |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Leon Ford</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Martin</b>  |  |  |  |   |  |  |  |   |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Ford (son)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>313 Rollins Ave, Capitol Heights, MD 20743</b>  |  |  |  |   |  |  |  |   |  |  |  |
|                                     |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Heritage Memorial Gardens</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Heritage Memorial Gardens</b>  |  | Date<br><b>4/30/2012</b>  |  | 20c. Location - City or Town, State<br><b>Waldorf, MD</b>  |  |   |  |  |  |   |  |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Jessica Cimire MCIS55</b>  |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNA CANCER</b>   |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>years</b>  |  |  |  |   |  |  |  |
|                                     |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |  |   |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |  |  |
|                                     |  |  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:   |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | Other:<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
|                                     |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |   |  |  |  |
|                                     |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Annapolis, MD 21401</b>  |  |  |  |   |  |  |  |   |  |  |  |
|                                     |  | 29b. Signature and title of certifier<br><b>Eva S. Hurl MD</b>   |  | 29c. License number<br><b>MD D0036581</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>   |  |  |  |   |  |  |  |   |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eva S. HERCH MD</b>   |  | 32. Registrar's Signature<br><b>Amena S. Parker</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |  |  |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15249

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death   |   | 3. Time of Death   |
| Ernest C. Fankhauser   |  | Month 04   | Day 22                                    | Year 2012  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |   | 4c. County of Death  |
| Charlotte Hall Veterans Nursing Ctr.   |  | Charlotte Hall   |   | Saint Mary's   |
| 5. Social Security Number<br>578-20-6548   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>89 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>09/01/1922   |
| If Under 1 Year<br>Months  |  | If Under 24 Hrs.<br>Hours  |   | 9. Birthplace (State or Foreign Country)<br>DC   |
| 10a. State<br>MD   |  | 10b. County<br>Anne Arundel  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br>296 Main Street  |  | 10f. Zip Code<br>20711   |   | 10g. Citizen of What Country?<br>United States   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12)<br>10   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |
| 17. Father's Name (First, Middle, Last)<br>Ernest Fankhauser   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Twila Mercillett  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Carolyn Carroll / Daughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>296 Main Street, Lothian, MD 20711  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery   |   | 20c. Location - City or Town, State<br>Cheltenham, MD  |
| 21. Signature of Funeral Service Licensee<br>► Gary J. Goff  |  | 22. Name and Address of Facility<br>Lee Funeral Home Calvert, P.A.<br>8200 Jennifer Lane, Owings, MD 20736   |   | Date 04/26/2012  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><i>FAILURE TO THRIVE</i><br>a. <i>SUBARACHNOID HEMORRHAGE</i>   |   | Approximate Interval Between Onset and Death<br>3 Weeks  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. <i>Due to (or as a consequence of):</i><br><i>CHRONIC KIDNEY DISEASE STAGE 3</i>  |   |  |
| c. <i>Due to (or as a consequence of):</i>   |  | d. <i>Due to (or as a consequence of):</i>   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DEMENTIA</i><br><i>HEART FAILURE</i><br><i>CHRONIC KIDNEY DISEASE STAGE 3</i>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Describe how injury occurred  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>H0037228MD  |   | 29d. Date signed (Month, Day, Year)<br>APRIL 23, 2012  |
| 29b. Signature and title of certifier<br>► <i>Stephen Coffey, MD</i>   |  | 32. Registrar's Signature<br><i>Stephen Coffey, MD</i>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stephen Coffey, MD - 22333 Greenview PKY, Unit A, Great Mills, MD 20634  |  | 31. Date filed (Month, Day, Year)<br>APR 24 2012   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15250

1- For  
State  
Registrar

Flint, Helen  
Baltimore, Maryland 21215-0036  
4/28/12 (01245)  
Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial certificate.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

|  |  |   |  |   |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  |   | 2. Date of Death<br>Month April Day 28 Year 2012   | 3. Time of Death<br>12:45 p M   |
| Helen F. Flint   |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br>Shady Grove Adventist Hospital   |  |   | 4b. City, Town, or Location of Death<br>Rockville  |   |
| 4c. County of Death<br>Montgomery  |  |   |  |   |
| 5. Social Security Number<br>577-34-3293   |  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>82 Yrs.   |
|  |  |   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.   |
|  |  |   | 8. Date of Birth<br>(Month Day Year)<br>10/30/1929   |   |
|  |  |   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |   |
| Usual Residence of Decedent<br>10a. State<br>Maryland  |  |   | 10b. County<br>Montgomery  |   |
| 10c. City, Town or Location<br>Silver Spring   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br>3322 Chiswick, #2E   |  |   | 10f. Zip Code<br>20906   | 10g. Citizen of What Country?<br>U.S.A.   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)                   |  | 16b. Kind of Business Industry<br>Homemaker Own Home  |
| 17. Father's Name (First, Middle, Last)<br>Robert Loudon   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gladys Edna Irene Turpin  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Stephen M. Flint - Son   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1413 Bernerd Place, Rockville, Maryland 20851 |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>► MBS/MSW/M 01524 |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory  | Date<br>05/03/2012  |
| 21. Signature of Funeral Service Licensee  |  |   | 20c. Location - City or Town, State<br>Brentwood, Maryland   |   |
| 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home, Inc.<br>11800 New Hampshire Ave., Silver Spring, MD 20904  |  |   |  |   |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |                          |  |                                   |
|--|--|---|--------------------------|--|-----------------------------------|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death  |                          |  |                                   |
| a. Due to (or as a consequence of):<br><br>Respiratory Failure   |  |   |                          |  |                                   |
| b. Due to (or as a consequence of):<br><br>multilobar pneumonia  |  |   |                          |  |                                   |
| c. Due to (or as a consequence of):<br><br>d. _____  |  |   |                          |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                          |  |                                   |
| 23d. Date of delivery<br>Month Day Year  |  |   |                          |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic obstructive pulmonary disease<br>coronary artery disease   |  |   |                          |  |                                   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 23f. Did alcohol contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                          |  |                                   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                          |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |                          |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                          |  |                                   |
| 29b. Signature and title of certifier<br>► G. Swapna   |  | 29c. License number<br>0069341  |                          | 29d. Date signed (Month, Day, Year)<br>4/29/12                                       |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Swapna Gaddipati MD 9901 Medical Ctr Dr Rockville, MD 20850  |  |   |                          |  |                                   |
| 31. Date filed (Month, Day, Year)<br>MAY 01 2012   |  | 32. Registrar's Signature<br>Linda J. Jones   |                          |  |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 1525

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |   |   |   |   |  |  |
|--|--|---|---|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | Isidore Forman  |   |   |   | 2. Date of Death<br>Month April Day 27 Year 2012        |  | 3. Time of Death<br>2:58 pM  |
| 4a. Facility Name (if not institution, give street and number)<br>5809 Nicholson Lane, #803  |  | 4b. City, Town, or Location of Death<br>Rockville   |   |   |   | 4c. County of Death<br>Montgomery                       |  |  |
| 5. Social Security Number<br>578-01-4109   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>96 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.                               | 8. Date of Birth<br>(Month, Day, Year)<br>June 02, 1915 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                       |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Rockville  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>5809 Nicholson Lane  |  | 10f. Zip Code<br>20852  |   |   |   | 10g. Citizen of What Country?<br>U.S.A.                 |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>2              |   | 16b. Kind of Business/Industry<br>Wholesaler  |   |   | 16c. Kind of Business/Industry<br>Liquor                         |  |
| 17. Father's Name (First, Middle, Last)<br>Alexander Forman  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida Weisberg |   |  |  |

|  |  |  |  |                    |   |
|--|--|--|--|--------------------|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Barry P. Forman - Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10200 Bent Cross Drive, Potomac, Maryland 20854 |  |                    |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King David Mem Grdns   |  | Date<br>04/30/2012 | 20c. Location - City or Town, State<br>Falls Church, Virginia |
| 21. Signature of Funeral Service Licensee<br>▶ Alex W. Forman  |  | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.<br>11800 New Hampshire Ave., Silver Spring, MD 20904                           |  |                    |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | Approximate Interval Between Onset and Death<br>3 Months |  |  |  |
| <p>a. Due to (or as a consequence of):<br/>Congestive Heart Failure</p> <p>b. Due to (or as a consequence of):<br/>Arteriosclerotic Heart Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>                                  |  |  |  |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |
|   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |

|   |   |  |  |  |  |   |   |
|---|---|--|--|--|--|---|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal Failure |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |   |   |
|   |   | <table border="1"> <tr> <td>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |   |   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|---|--|---|--|--|--|

|   |  |  |                          |  |  |
|---|--|--|--------------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D13818                         |  |  |  |
| 29b. Signature and title of certifier<br>▶ Gary Fisher, M.D.   |  | 29d. Date signed (Month, Day, Year)<br>April 28, 2012 |  |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gary Fisher, M.D., 5530 Wisconsin Avenue, Suite 700, Chevy Chase, MD 20815 |  | 31. Date filed (Month, Day, Year)<br>MAY 01 2012 |  |  |  |
|  |  | 32. Registrar's Signature<br>▶ Gary S. Fisher    |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit B.

Medical Certificate: To Be Completed by Physician/Medical Examiner

10

## Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 20b per fh g927 5-18-12 vt  
 State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

## Certificate of Death

Reg. No. 2012 15252

Physician/  
Medical  
Examiner

|  |  |  |                  |  |                  |  |
|--|--|--|------------------|--|------------------|--|
| 1. Decedent's Name (First, Middle, Last) |  |  | 2. Date of Death |  | 3. Time of Death |  |
| Sarah Eva Ferguson                       |  |  | April 26, 2012   |  | 8:49 P.M.        |  |

Funeral  
Director

|  |  |  |                                      |  |  |                     |  |
|--|--|--|--------------------------------------|--|--|---------------------|--|
| 4a. Facility Name (if not institution, give street and number) |  |  | 4b. City, Town, or Location of Death |  |  | 4c. County of Death |  |
| Southern Maryland Hospital                                     |  |  | Clinton                              |  |  | Prince George's     |  |

To Be Completed by Funeral Director

|                           |  |                                |                 |                  |                    |  |  |
|---------------------------|--|--------------------------------|-----------------|------------------|--------------------|--|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth   | 9. Birthplace (State or Foreign Country) |  |
| 577-58-4979               | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 68 Yrs.                        | Months          | Days             | (Month, Day, Year) | 08/28/1943 Wash., D.C.                   |  |

|                             |                 |                             |  |  |  |  |  |
|-----------------------------|-----------------|-----------------------------|--|--|--|--|--|
| Usual Residence of Decedent |                 | 10d. Inside City Limits     |  |  |  |  |  |
| 10a. State                  | 10b. County     | 10c. City, Town or Location |  |  |  |  |  |
| Md.                         | Prince George's | Clinton                     |  |  |  |  |  |

|                        |  |  |               |  |  |                               |  |  |
|------------------------|--|--|---------------|--|--|-------------------------------|--|--|
| 10e. Street and Number |  |  | 10f. Zip Code |  |  | 10g. Citizen of What Country? |  |  |
| 9211 Stuart Lane       |  |  | 20735         |  |  | U.S.A.                        |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |  | 14. Race - American Indian, Black, White, etc. |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |  | Specify: Black                                 |  |  |

|   |                     |   |  |  |                                |  |  |
|---|---------------------|---|--|--|--------------------------------|--|--|
| 15. Decedent's Education (Specify only highest grade completed) |                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |  | 16b. Kind of Business/Industry |  |  |
| Elementary/Secondary (0-12)                                     | College (1-4 or 5+) | Cosmetologist   |  |  | Cosmetology                    |  |  |
| 10th  |                     |   |  |  |                                |  |  |

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| 17. Father's Name (First, Middle, Last) |  |  | 18. Mother's Name (First, Middle, Maiden Surname) |  |  |  |  |  |
| Alfred Sherman Thomas                   |  |  | Helen Louise Randall                              |  |  |  |  |  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |  |  |  |
| Marilyn Chappell/Sister                          |  | 1736 Addison Road S., District Heights, Md. 20747   |  |  |  |  |  |

|   |  |        |                                     |  |  |
|---|--|--------|-------------------------------------|--|--|
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date   | 20c. Location - City or Town, State |  |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | Chesapeake Crematory, Inc. <input checked="" type="checkbox"/>         | 5-8-12 | Beltsville, Md.                     |  |  |

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility   |
| <i>Jacey R. Scott</i> #CC0316             | Henry S. Washington & Sons Co., Inc.<br>4925 Turnrows Ave., N.E., Washington, D.C. 20019 |

|   |  |  |  |
|---|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | <i>Ischemic Cardiovascular Disease Acute</i> |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. Due to (or as a consequence of):          |  |  |
|   | b. Due to (or as a consequence of):          |  |  |
|   | c. Due to (or as a consequence of):          |  |  |
|   | d. _____                                     |  |  |

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown | 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (Specify) _____ | 23d. Date of delivery<br>Month Day Year |  |  |
|--|---|--|---|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                      |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| <i>Hypertension<br/>Diabetes<br/>Breast Cancer</i>  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|---|--|--|--|--|--|

|  |  |                          |  |  |  |
|--|--|--------------------------|--|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
|--|--|--|--|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 29b. Signature and title of certifier<br><i>[Signature]</i> | 29c. License number<br><i>50065111</i> | 29d. Date signed (Month, Day, Year)<br><i>4/26/12</i> |  |  |  |
|---|--|---|--|--|--|

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | <i>Michael Fraser 7503 Surratts Rd. Clinton, Md 20735</i> |  |  |  |  |
|--|---|--|--|--|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><i>MAY 01 2012</i> | 32. Registrar's Signature<br><i>Susan B. Parker</i> |
|---|---|

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15253

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 must be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

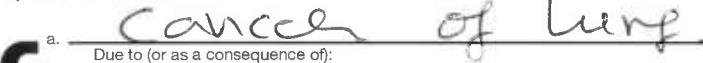
Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

|  |  |   |  |   |   |   |  |  |  |  |  |  |                                   |  |
|--|--|---|--|---|---|---|--|--|--|--|--|--|-----------------------------------|--|
|  |  | 1. Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death<br>Month Day Year  |   |  | 3. Time of Death   |  |  |  |  |                                   |  |
|  |  | <b>Jonathan Christopher Hartmann</b>  |  |   | April 28, 2012  |   |  | 8:15 p M   |  |  |  |  |                                   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 4a. Facility Name (if not institution, give street and number)  |  |   | 4b. City, Town, or Location of Death  |   |  | 4c. County of Death  |  |  |  |  |                                   |  |
|  |  | 5451 Chicamuxen Road  |  |   | Indian Head   |   |  | Charles  |  |  |  |  |                                   |  |
| Funeral<br>Director  |  | 5. Social Security Number   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>55 Yrs.   | If Under 1 Year<br>Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Aug. 11, 1956   |  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  |  |  |  |                                   |  |
|  |  | Usual Residence of Decedent   |  |   | 10c. City, Town or Location   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |  |                                   |  |
|  |  | Maryland  | Charles  | Indian Head   |   |   |  |  |  |  |  |  |                                   |  |
| To Be Completed by Funeral Director                                |  | 10a. State  |  |   | 10b. County   |   |  | 10f. Zip Code  |  |  |  |  |                                   |  |
|  |  | Maryland  |  |   | Charles   |   |  | 20640  |  |  |  |  |                                   |  |
|  |  | 10e. Street and Number  |  |   | 10f. Zip Code   |   |  | 10g. Citizen of What Country?  |  |  |  |  |                                   |  |
|  |  | 5451 Chicamuxen Road  |  |   |   |   |  | U.S.A.   |  |  |  |  |                                   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |                                   |  |
|  |  | 1 Elementary/Seconday (0-12)  |  | College (1-4 or 5+)   |   | 15. Decedent's Education<br>(Specify only highest grade completed)  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired) |  | 16b. Kind of Business Industry   |  |                                   |  |
|  |  | 12  |  |   |   | Supervisor  |  |  |  |  | Electrical Company   |  |                                   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 17. Father's Name (First, Middle, Last)   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)   |   |  |  |  |  |  |  |                                   |  |
|  |  | Gail Hartmann   |  |   | Mary Catherine Badour   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |   |  |  |  |  |  |  |                                   |  |
|  |  | Kathryn Hartmann Wife   |  |   | 5451 Chicamuxen Rd., Indian Head, Md. 20640   |   |  |  |  |  |  |  |                                   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 20a. Method of Disposition  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   |  | 20c. Location - City or Town, State  |  |  |  |  |                                   |  |
|  |  | <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Funeral Service  |  |   | May 2, 2012   |   |  | Alexandria, Virginia   |  |  |  |  |                                   |  |
| To Be Completed by Funeral Director                                |  | 21. Signature of Funeral Service Licensee   |  |   | 22. Name and Address of Facility  |   |  |  |  |  |  |  |                                   |  |
|  |  |    |  |   | Williams Funeral Home, P.A.<br>M00668 4270 Hawthorne Rd., Indian Head, Md. 20640  |   |  |  |  |  |  |  |                                   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   | Approximate Interval Between Onset and Death  |   |  |  |  |  |  |  |                                   |  |
|  |  | Immediate Cause (Final disease or condition resulting in death)   |  |   |   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | a. Due to (or as a consequence of):<br><br>   |  |   |   |   |  |  |  |  |  |  |                                   |  |
|  |  | b. Due to (or as a consequence of):   |  |   |   |   |  |  |  |  |  |  |                                   |  |
|  |  | c. Due to (or as a consequence of):   |  |   |   |   |  |  |  |  |  |  |                                   |  |
|  |  | d. _____  |  |   |   |   |  |  |  |  |  |  |                                   |  |
| IF FEMALE:   |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |  |  |                                   |  |
|  |  |   |  |   |   |   |  |  |  |  |  |  |                                   |  |
|  |  |   |  |   |   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)        |   |  |  |  |  |  |  |                                   |  |
|  |  |   |  |   |   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |   | 28a. Date of injury (Month, Day, Year)  |   |  | 28b. Time of injury  |  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|  |  |   |  |   | M   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |                                   |  |
|  |  |   |  |   |   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number   |   |  | 29d. Date signed (Month, Day, Year)  |  |  |  |  |                                   |  |
|  |  |    |  |   | D2F352  |   |  | 4-29-12  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |   |   |  |  |  |  |  |  |                                   |  |
|  |  | PO Box 1703 LaPlata MD 20646  |  |   |   |   |  |  |  |  |  |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)   |  |   | 32. Registrar's Signature   |   |  |  |  |  |  |  |                                   |  |
|  |  | MAY 01 2012   |  |   | Leanne A. Parker  |   |  |  |  |  |  |  |                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15254

Reg. No.

1 - For  
State  
Registrar

|  |  |   |   |   |   |   |  |   |  |
|--|--|---|---|---|---|---|--|---|--|
| Physician/<br>Medical<br>Examiner                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Marjorie Catherine Huici</b>   |   |   |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>20</b> Year <b>2012</b>  | 3. Time of Death<br><b>11:15 p</b> M                  |  |
| Funeral<br>Director  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Doctors Community Hospital</b>   |   |   |   |   | 4b. City, Town, or Location of Death<br><b>Lanham</b>  | 4c. County of Death<br><b>Prince George's</b>         |  |
| To Be Completed by Funeral Director                                |  | 5. Social Security Number<br><b>092-14-9400</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>92</b> Yrs.  | If Under 1 Year<br>Months      Days      Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>04/21/1919</b> | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b>  |   |  |
|  |  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Prince George's</b>   | 10c. City, Town or Location<br><b>Mitchellville</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
|  |  | 10e. Street and Number<br><b>10450 Lottsford Road</b>   |   |   | 10f. Zip Code<br><b>20721</b>   | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |  |   |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br>white          | 14. Race - American Indian, Black, White, etc.<br>Specify:  |   |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>2</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>nurse</b>                                    | 16b. Kind of Business/Industry<br><b>hospital</b>   |   |  |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Daniel Hanrahan</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Sheehe</b>  |   |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy Freije, daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10230 Shirley Meadow Ct., Ellicott City, MD 21042</b> |   |  |   |  |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   | Date<br><b>04/23/12</b>   | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>  |   |  |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.</b><br><b>8325 Mt. Harmony Lane, Owings, MD 20736</b>  |   |   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Aspiration Pneumonia</b>   |   |   |   |   | Approximate Interval Between Onset and Death   |   |  |
|  |  | b. Due to (or as a consequence of):<br><b>Urinary Tract Infection</b>   |   |   |   |   |  |   |  |
|  |  | c. Due to (or as a consequence of):   |   |   |   |   |  |   |  |
|  |  | d. Due to (or as a consequence of):   |   |   |   |   |  |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |   |   |  | 23d. Date of delivery<br>Month      Day      Year     |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|  |  |   |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                           |  |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |   |  |
|  |  | 29b. Signature and title of certifier<br>   | 29c. License number<br><b>MDJ 53718</b>   |   |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>4/22/12</b> |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. Thomas Hansson 818 Good Luck Road, Lanham, MD 20706</b>  |   |   |   |   |  |   |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>APR 24 2012</b>   | 32. Registrar's Signature<br>   |   |   |   |  |   |  |

Huici, Marjorie  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15255

## 1- For State Registrar

|  |  |                  |  |                |                                    |                              |
|--|--|------------------|--|----------------|------------------------------------|------------------------------|
| <b>Physician/<br/>Medical Examiner</b> | 1. Decedent's Name (First, Middle, Last) | Zoe Irene Hauser |  |                | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1854 hrs |
|  |  |                  |  | April 20, 2012 |                                    |                              |

## Funeral Director

|  |   |                                  |
|--|---|----------------------------------|
| 4a. Facility Name (if not institution, give street and number)<br>1202 Beechwood Drive | 4b. City, Town, or Location of Death<br>Frederick | 4c. County of Death<br>Frederick |
|--|---|----------------------------------|

## Usual Residence of Decedent

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 5. Social Security Number<br>218-39-4198 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>18 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>08/30/1993 | 9. Birthplace (State or Foreign Country)<br>Maryland |
|--|--|---|---|---|--|

## Important: If item 27 is marked other than "natural", or items 2a or 2a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

## To Be Completed by Funeral Director

|                  |                          |  |  |
|------------------|--------------------------|--|--|
| 10a. State<br>MD | 10b. County<br>Frederick | 10c. City, Town or Location<br>Frederick | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|------------------|--------------------------|--|--|

|  |                        |   |
|--|------------------------|---|
| 10e. Street and Number<br>1202 Beechwood Drive | 10f. Zip Code<br>21701 | 10g. Citizen of What Country?<br>U.S.A. |
|--|------------------------|---|

|  |  |   |  |
|--|--|---|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|--|--|---|--|

|  |   |  |
|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Student | 16b. Kind of Business/Industry<br>School |
|--|---|--|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br>Donald Robert Hauser | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lori Spaid |
|---|---|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Donald Hauser/Father | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1202 Beechwood Drive, Frederick, Maryland 21701 |
|--|--|

|   |  |                  |   |
|---|--|------------------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Crematory | Date<br>04/23/12 | 20c. Location - City or Town, State<br>Smithsburg, Maryland |
|---|--|------------------|---|

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br>Robert E. Dailey & Son Funeral Homes, P.A.,<br>1201 North Market Street, Frederick, MD, 21701 |
|---|---|

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Asphyxia<br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|---|--|

|  |  |
|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Hanging<br>Due to (or as a consequence of): |  |
|--|--|

|  |  |
|--|--|
| c. _____<br>Due to (or as a consequence of): |  |
|--|--|

|  |  |
|--|--|
| d. _____<br>UNPENDED <input type="checkbox"/> AMENDED <input type="checkbox"/> |  |
|--|--|

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|--|

|  |  |  |   |  |
|--|--|--|---|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury<br>Month Day Year<br>FOUND: Apr 20, 2012 | 28b. Time of Injury<br>FOUND: 1845 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Subject hanged self |
|--|--|--|---|--|

|  |   |
|--|---|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Single Family Home | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1202 Beechwood Drive, Frederick, MD |
|--|---|

|   |                                 |   |
|---|---------------------------------|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>April 21, 2012 |
|---|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|---|

|  |                               |
|--|-------------------------------|
| 31. Date filed (Month, Day, Year)<br>APR 27 2012 | 32. Registrar's Signature<br> |
|--|-------------------------------|

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15256

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |   |  |   |                                |  |  |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  |   |                                | 3. Time of Death                                     |  |
| John Derwood Harris  |  | April 26 2012   |  |   |                                | 10:50 AM   |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |  |   |                                | 4c. County of Death                                  |  |
| 1370 Mutual Court  |  | Port Republic   |  |   |                                | Calvert  |  |
| 5. Social Security Number  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs.    | If Under 1 Year<br>Months Days Hours Min.   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>01/26/1927 | 9. Birthplace (State or Foreign Country)<br>New York   |
| 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>85 Yrs.   |  |   |                                |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Calvert  | 10c. City, Town or Location<br>Port Republic |   |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>1370 Mutual Court  |  | 10f. Zip Code<br>20676  |  |   |                                | 10g. Citizen of What Country?<br>United States       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. 1944-46 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Auto Mechanic             |  | 16b. Kind of Business Industry<br>Automotive  |                                |  |  |
| 17. Father's Name (First, Middle, Last)<br>Melkon Saajitian  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lola Kell  |  |   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy Harris / Wife  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1370 Mutual Court, Port Republic, Maryland 20676             |  |   |                                |  |  |

|   |  |                    |  |
|---|--|--------------------|--|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Highland                          | Date<br>05/01/2012 | 20c. Location - City or Town, State<br>Port Republic, Maryland |
| 21. Signature of Funeral Service Licensee<br>► Kyle S. Simons MD1206  | 22. Name and Address of Facility<br>Rausch Funeral Home, PA<br>4405 Broomes Island Road, Port Republic, Maryland 20676 |                    |  |

|  |  |   |   |
|--|--|---|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | Approximate Interval Between Onset and Death  |   |
| <p>a. Due to (or as a consequence of):<br/><i>Congestive Heart Failure</i></p> <p>b. Due to (or as a consequence of):<br/><i>Atherosclerotic cardiovascular Disease</i></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>   |  |   |   |
| 23b. If Female:<br>Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |

|   |   |  |  |                                   |
|---|---|--|--|-----------------------------------|
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown        |   | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                   |
|   |   | 23g. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                           |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |

|  |  |                               |  |
|--|--|-------------------------------|--|
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier<br>► | 29c. License number<br>033123 | 29d. Date signed (Month, Day, Year)<br>4-27-12 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jonathan Lowenthal, MD 110 Hospital Road, Prince Frederick, Maryland 20678   |  |                               |  |

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>APR 30 2012 | 32. Registrar's Signature<br>Lorraine L. Parker |
|--|---|

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15257

**1 - For  
State  
Registrar**

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>CORINNE T.W.HAIRSTON</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>04/23/2012</b>         | 3. Time of Death<br>8:10 A M   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Manor Care Potomac</b>  |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |   | 4c. County of Death<br><b>Montgomery</b>                        |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>579-26-6209</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>85</b><br>Yrs.  | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month Day Year)<br><b>08/28/1926</b>  | 9. Birthplace (State or Foreign Country)<br><b>SC</b>           |  |
|   | Usual Residence of Decedent<br><b>MD Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <b>To Be Completed by Funeral Director</b>  | 10e. Street and Number<br><b>2424 Portage Road</b>   |  |  | 10f. Zip Code<br><b>20906</b>   | 10g. Citizen of What Country?<br><b>USA</b>                     |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) <b>College (1-4 or 5+)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Financial Analyst-HEW</b>       |   | 16b. Kind of Business Industry<br><b>Government</b>             |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Robinson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jamison</b>   |   |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Hairston/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2424 Portage Road, Silver Spring, MD 20906</b> |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Gate of Heaven</b> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven</b>  | Date<br><b>4/27/2012</b>  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b> |  |
| 21. Signature of Funeral Service Licensee<br><b>George R. Snowden</b>   |  | 22. Name and Address of Facility<br><b>Snowden Funeral Home<br/>246 N. Washington St, Rockville, MD 20850</b>  |  |   |   |  |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Advanced endstage dementia</b> Due to (or as a consequence of): _____ years</p> <p>b. <b>Alzheimers disease</b> Due to (or as a consequence of): _____ years</p> <p>c. _____ Due to (or as a consequence of): _____</p> <p>d. _____</p>  |  |  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown      |  |   | 23d. Date of delivery<br>Month Day Year                         |  |
| <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>Thrombocytopenia</b></p> <p><b>Purpura</b></p>  |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p> |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                               |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Loreto S. Albiol MD</b>   |  | 29c. License number<br><b>D31319</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/23/2012</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Loreto S. Albiol 8218 Wisconsin Avenue, #305, Bethesda, MD 20814</b>   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |  | 32. Registrar's Signature<br><b>Severa S. Jones</b>  |  |   |   |  |

**Baltimore, Maryland 21215-0036**

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial transcript.

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

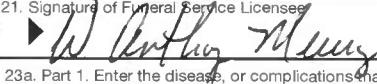
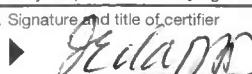
Certificate of Death

Reg. No.

2012 15258

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |  |                                |  |   |  |                                     |  |           |
|---|--|--|--------------------------------|--|---|--|-------------------------------------|--|-----------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |                                |  |   | 3. Time of Death<br>2:14P M  |                                     |  |           |
| Michele Havilland   |  | 04/28/2012   |                                |  |   |  |                                     |  |           |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death   |                                |  |   | 4c. County of Death  |                                     |  |           |
| JK House of Grace   |  | Silver Spring  |                                |  |   | Montgomery   |                                     |  |           |
| 5. Social Security Number   |  | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.  | 8. Date of Birth<br>(Month Day Year)   |                                     | 9. Birthplace (State or Foreign Country)   |           |
| 301 26 1603   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 91 Yrs.                        | Months   | Days  | Hours  | Min.                                | 05/23/1920   | Indochina |
| Usual Residence of Decedent   |  |  |                                |  |   |  |                                     |  |           |
| 10a. State  |  | 10b. County  |                                | 10c. City, Town or Location  |   |  |                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |           |
| WA  |  | Clark  |                                | Washogal   |   |  |                                     |  |           |
| 10e. Street and Number  |  | 10f. Zip Code  |                                |  |   | 10g. Citizen of What Country?  |                                     |  |           |
| 2616 NE 387th Avenue  |  | 98671  |                                |  |   | United States  |                                     |  |           |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |           |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |                                |  |   |  |                                     |  |           |
| 15. Decedent's Education<br>(Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |                                |  |   | 16b. Kind of Business/Industry   |                                     |  |           |
| Elementary/Secondary (0-12)   |  | College (1-4 or 5+)  |                                |  |   | Homemaker Own Home   |                                     |  |           |
| 12  |  |  |                                |  |   |  |                                     |  |           |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)  |                                |  |   |  |                                     |  |           |
| Maurice Henry Drapeau   |  | Claire Legendre  |                                |  |   |  |                                     |  |           |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                                |  |   |  |                                     |  |           |
| Lance Havilland/Son   |  | 2616 NE 387th Avenue Washogal, WA 98671  |                                |  |   |  |                                     |  |           |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                |  |   | Date   | 20c. Location - City or Town, State |  |           |
|   |  | National Crematory   |                                |  |   | 05/01/2012   | Falls Church, VA                    |  |           |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave., NW Washington, DC 20016  |                                |  |   |  |                                     |  |           |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____  |                                |  |   | 23d. Date of delivery<br>Month Day Year  |                                     |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. Due to (or as a consequence of):<br>a. CONGESTIVE HEART FAILURE   |                                |  |   | Approximate Interval Between Onset and Death   |                                     |  |           |
| {   |  |  |                                |  |   |  |                                     |  |           |
|   |  | b. ATRIAL FIBRILLATION   |                                |  |   |  |                                     |  |           |
|   |  | c. HYPERTENSION  |                                |  |   |  |                                     |  |           |
|   |  | d. POLYMYALGIA RHEUMATICA  |                                |  |   |  |                                     |  |           |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. Due to (or as a consequence of):  |                                |  |   | 23d. Date of delivery<br>Month Day Year  |                                     |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PERIPHERAL VASCULAR DISEASE   |  |  |                                |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                     |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Asst. Living |                                |  |   | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                     |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  |                                | 28b. Time of Injury  | M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred   |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |                                     |  |           |
|   |  |  |                                |  |   |  |                                     |  |           |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                |  |   | 29c. License number  |                                     |  |           |
|   |  |  |                                |  |   | D 37830  |                                     |  |           |
| 29b. Signature and title of certifier<br>  |  |  |                                |  |   | 29d. Date signed (Month, Day, Year)  |                                     |  |           |
|   |  |  |                                |  |   | 04 - 30 - 2012   |                                     |  |           |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |  |                                |  |   |  |                                     |  |           |
| JOHNY EDAPPULLY 3416 Olandwood Court #207 Olney, MD 20832   |  |  |                                |  |   |  |                                     |  |           |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature  |                                |  |   |  |                                     |  |           |
| MAY 01 2012   |  |   |                                |  |   |  |                                     |  |           |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit B

Medical Certificate: To Be Completed by Physician/Medical Examiner

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15259

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
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Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.

Physician/  
Medical  
Examiner

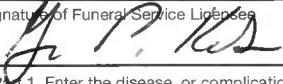
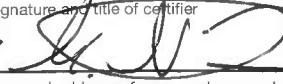
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Division of Vital Records, P.O. Box 68760

State  
Registrar

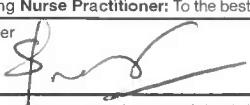
|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death  |   | 3. Time of Death  |   |
| Amelia Interdonato   |  | Month April Day 25, 2012 Year   |   | 7:56 P M  |   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death   |   |
| 12301 Hatton Point Road  |  | Ft. Washington  |   | Prince George's   |   |
| 5. Social Security Number  |  | 6. Sex  |   | 7. Age (In yrs. last birthday)  |   |
| 215-01-8527  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 93 Yrs.   |   |
| Usual Residence of Decedent  |  | If Under 1 Year<br>Months   |   | If Under 24 Hrs<br>Hours  |   |
| 10a. State Maryland  |  | 10b. County Prince George's   |   | 10c. City, Town or Location Ft. Washington  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |   |
| 10e. Street and Number<br>12301 Hatton Point Rd.   |  | 10f. Zip Code<br>20744  |   | 10g. Citizen of What Country?<br>USA  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Homemaker   |   | 16b. Kind of Business/Industry<br>In Home   |   |
| 17. Father's Name (First, Middle, Last)<br>Antonio Mirabile  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosaria Mirabile |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Paul Interdonato / Husband   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12301 Hatton Point Rd. Ft. Washington, MD 20744  |   |   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entomb   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cem.   |   | Date<br>5/5/2012  | 20c. Location - City or Town, State<br>Suitland, Maryland |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home PA<br>6160 Oxon Hill Rd. Oxon Hill, Maryland 20745   |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br>years   |   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |   |   |
| a. _____ Due to (or as a consequence of):<br><br>Dementia   |  |   |   |   |   |
| b. _____ Due to (or as a consequence of):  |  |   |   |   |   |
| c. _____ Due to (or as a consequence of):  |  |   |   |   |   |
| d. _____   |  |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |   |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred                         |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |   |
| 29b. Signature and title of certifier<br><br>ANP-BC   |  | 29c. License number<br>AC000937   |   | 29d. Date signed (Month, Day, Year)<br>April 27, 2012   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Melanie Reynolds ANP-BC 9200 Basil Ct. Ste 200 Largo MD 20774  |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 01 2012   |  | 32. Registrar's Signature<br>  |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15260

Reg. No.

|                                     |  |  |                                       |   |   |   |  |  |  |                               |   |
|-------------------------------------|--|--|---------------------------------------|---|---|---|--|--|--|-------------------------------|---|
| 1 - For State Registrar             |  | 1. Decedent's Name (First, Middle, Last)<br><b>James Jessie Jr.</b>  |                                       |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 20, 2012</b>  |  | 3. Time of Death<br>12:45 P M |   |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>4008 28th Avenue Apt. # 104</b>   |                                       |   | 4b. City, Town, or Location of Death<br><b>Temple Hills</b>   |   |  | 4c. County of Death<br><b>Prince George's</b>  |  |                               |   |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>205-28-8326</b>  | 6. Sex<br><b>1 M 2 F</b>              | 7. Age (In yrs. last birthday)<br><b>73</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 24, 1939</b>                       | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |                               |   |
| To Be Completed by Funeral Director |  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince George's</b> | 10c. City, Town or Location<br><b>Temple Hills</b>  |   |   | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>                                       |  |  |                               |   |
|                                     |  | 10e. Street and Number<br><b>4008 28th Avenue Apt. 104</b>   |                                       |   | 10f. Zip Code<br><b>20748</b>   |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |                               |   |
|                                     |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>    |                               |   |
|                                     |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b>                        |   |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |                               |   |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>James Jessie Sr.</b>   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Vaughn</b>   |  |  |  |                               |   |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kyle G. Jessie - Son</b>  |                                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13908 Barrington Lane Upper Marlboro, Md. 20772</b> |   |  |  |  |                               |   |
|                                     |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>   |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee's Crematory</b>  |   |  | Date<br><b>April 28, 2012</b>  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>              |                               |   |
|                                     |  | 21. Signature of Funeral Service Licensee<br>   |                                       |   | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc.</b>   |   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |                               | Approximate Interval Between Onset and Death  |
|                                     |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last  |                                       |   | Coronary Artery Disease   |   |  |  |  |                               |   |
|                                     |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |                                       |   |   |   |  |  |  |                               |   |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |                                       | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |  |  |                               |   |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                       |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |                               |   |
|                                     |  |  |                                       |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |   |  |  |  |                               |   |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |                                       | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |                               |   |
|                                     |  |  |                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                               |   |
|                                     |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                       | 29c. License number<br><b>D46478</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>April 25, 2012</b>                         |  |  |                               |   |
|                                     |  | 29b. Signature and title of certifier<br>   |                                       |   |   |   |  |  |  |                               |   |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Suresh A. Patel 7501 Surratts Road Clinton, Maryland 20735</b>  |                                       |   |   |   |  |  |  |                               |   |
| State Registrar                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |                                       | 32. Registrar's Signature<br>  |   |   |  |  |  |                               |   |

Baltimore, Maryland 21215-0036  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 1526

**1 - For  
State  
Registrar**

|   |   |   |  |   |                          |   |  |   |
|---|---|---|--|---|--------------------------|---|--|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 1. Decedent's Name (First, Middle, Last)<br><i>Daniel C. Johns</i>  |   |  |   |                          |   | 2. Date of Death<br>Month <b>04</b> Day <b>17</b> Year <b>2012</b>   | 3. Time of Death<br><b>602 A M</b>                          |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Washington Adventist Hospital</b>  |   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |                          |   | 4c. County of Death<br><b>Montgomery</b>   |   |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>213-78-0612</b>   | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/9/1959</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |   |
|   | Usual Residence of Decedent<br><b>Md Prince George's</b>  |   |  | 10c. City, Town or Location<br><b>Brentwood</b>   |                          |   | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   |
| <b>To Be Completed by Funeral Director</b>                                | 10e. Street and Number<br><b>3818 Allison St.</b>   |   |  | 10f. Zip Code<br><b>20722</b>   |                          |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>   |                          |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10</b>   |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Truck Driver</b>   |                          |   | 16b. Kind of Business Industry<br><b>Private</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Benjamin A. Johns</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia R. Rowe</b>  |                          |   |  |   |
| <b>Division of Vital Records, P.O. Box 68760</b>                          | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathryn Johns / Sister</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3818 Allison St. Brentwood, Md. 20722</b>   |                          |   |  |   |
|   | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>  |                          |   | Date<br><b>4/19/2012</b>   | 20c. Location - City or Town, State<br><b>Brentwood, Md</b> |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 21. Signature of Funeral Service Licensee<br><i>Preston Maxus</i>   |   |  | 22. Name and Address of Facility<br><b>3401 Baldensburg Rd Brentwood, Md 20722<br/>Ft. Lincoln Funeral Home</b>   |                          |   |  |   |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  | 23b. Due to (or as a consequence of):<br><br><i>COPD</i>  |                          |   | Approximate Interval Between Onset and Death   |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>  |   |  | 23d. Date of delivery<br>Month Day Year   |                          |   |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>   |                          |   |  |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |                          |   |  |   |
|   | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DCA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |                          |   |  |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred  |   |
|   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  | 29c. License number<br><b>12207</b>   |                          |   | 29d. Date signed (Month, Day, Year)<br><b>1/26/2012</b>  |   |
|   | 29b. Signature and title of certifier<br><i>Anna Ansaldo</i>  |   |  |   |                          |   |  |   |
| <b>State<br/>Registrar</b>  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Anna Ansaldo<br/>7600 Carroll Ave., Takoma Park Md. 20912</b>  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |                          |   | 32. Registrar's Signature<br><i>Anna J. Ansaldo</i>  |   |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

*E.G.*

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15262

1. For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Beatrice Harriet Keefer

Reg. No.

2. Date of Death

Month Day Year

3. Time of Death

1650 hrs

Physician/  
Medical Examiner

4a. Facility Name (if not institution, give street and number)

4500 Block of Maryland Hwy

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or  
Foreign Country)

220-40-2259

1  M 2  F

84 Yrs.

Months

Days

Hours

Min.

Nov. 4, 1927

WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

MD Garrett

Oakland

1  Yes 2  No

10e. Street and Number

525 Popular Street

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married3  Widowed4  Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1  Yes2  NoIf Yes, Give Year  
or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:14. Race - American Indian, Black,  
White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John W.

18. Mother's Name (First, Middle, Maiden Surname)

Nair Edna Florence Stahl

19a. Informant's Name/Relationship (Type, Print)

Ralph E. Keefer/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 Southern Pines Dr., Oakland, MD 21550

20a. Method of Disposition

1  Burial2  Cremation3  Removal from State4  Donation5  Other Specify:20b. Place of Disposition (Name of cemetery,  
crematory or other place)

Garrett County

Date

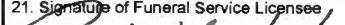
20c. Location - City or Town, State

Memorial Gardens

4/28/12

Oakland, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Newman Funeral Homes P.A.

203 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval  
Between Onset and  
DeathImmediate Cause (Final disease  
or condition resulting in death)

e. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying Cause  
(Disease or injury that initiated  
events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the  
past 12 months?1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No25. Was case referred to medical  
examiner?1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA 4  Nursing Home 5  Residence 6  Other: Scene

27. Manner of Death

1  Natural

28a. Date of Injury

(Month, Day, Year)

Apr 25, 2012

5  Pending  
Investigation

28b. Time of Injury

1655 hrs

28c. Injury at Work?

1  Yes 2  No3  Accident4  Suicide6  Could not be  
determined7  Homicide

28d. Describe how injury occurred

Passenger in a car that ran into the back of a truck

8  Motor Vehicle  
9  Fall  
10  Drowning  
11  Drown  
12  Drown  
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| <b>Physician/<br/>Medical Examiner</b>                                      | 1- For State<br>Registrar   |  |   |   |   |   | 2. Date of Death<br>Month Day Year   |   |  | 3. Time of Death<br>1650 hrs   |     |  |
|   | 1. Decedent's Name (First, Middle, Last)<br><b>Ralph Playford Keefer</b>  |  |   |   |   |   | 4a. Facility Name (if not institution, give street and number)<br>4500 Block Maryland Highway  |   |  | 4b. City, Town, or Location of Death<br>Oakland  |     |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>213-24-6300</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>83 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (MM/DD/YYYY)<br><b>Dec. 2, 1928</b>   | 9. Birthplace (State or<br>Foreign Country)<br><b>MD</b>  |  |  |     |  |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Garrett</b>   |   | 10c. City, Town or Location<br><b>Oakland</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |     |  |
| <b>To Be Completed by Funeral Director</b>                                  | 10e. Street and Number<br><b>525 Popular Street</b>   |  |   |   | 10f. Zip Code<br><b>@1550</b>   |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |     |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |  |     |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Unk</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Keefer</b>  |   |  |   |  |  |     |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ralph E. Keefer/ Son</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>605 Southern Pines Dr., Oakland, MD 21550</b>   |   |  |   |  |  |     |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>Rebecca L. Maltby Jr.</i>            |  |   |   | 20b. Place of Disposition (Name of cemetery, Cemetery or other place)<br><b>Garrett Cemetery Memorial Gardens</b>   |   | Date<br><b>4/28/12</b>   | 20c. Location - City or Town, State<br><b>Oakland, Maryland</b>   |  |  |     |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Rebecca L. Maltby Jr.</i>   |  |   |   | 22. Name and Address of Facility<br><b>Newman Funeral Homes P.A.</b><br><b>203 S. Second St., Oakland, MD 21550</b>   |   |  |   |  |  |     |  |
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |   |   |  |   |  | Approximate Interval Between Onset and Death   |     |  |
|   | a. Head and Neck Injuries<br>Due to (or as a consequence of):   |  |   |   |   |   |  |   |  |  |     |  |
|   | b.<br>Due to (or as a consequence of):  |  |   |   |   |   |  |   |  |  |     |  |
|   | c.<br>Due to (or as a consequence of):  |  |   |   |   |   |  |   |  |  |     |  |
|   | d.<br>Due to (or as a consequence of):  |  |   |   |   |   |  |   |  |  |     |  |
|   | <input type="checkbox"/> UNPENDED   |  | <input type="checkbox"/> AMENDED  |   |   |   |  |   |  |  |     |  |
|   | IF FEMALE:  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |   |   |  |   |  | 23d. Date of delivery<br>Month Day Year  |     |  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |   |   |   |  |   |  | Month  | Day | Year   |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b> | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |     |  |
|   |   |  |   |   |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |     |  |
|   |   |  |   |   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |     |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene     |   |   |   |  |   |  |  |     |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>Apr 25, 2012</b>  |   | 28b. Time of Injury<br>1655 hrs   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Driver of a car that ran into the back of a parked truck  |   |  |  |     |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br><b>Major Road / Highway</b>  |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4500 Block Maryland Highway, Oakland, MD</b> |  |  |     |  |
|   | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)  |  | 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i>  |   |   |   |  |   |  | 29c. License number<br><b>O.C.M.E.</b>   |     | 29d. Date signed (Month, Day, Year)<br><b>April 26, 2012</b> |
|   | 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |   |  |   |  |  |     |  |
|   | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |   |   |   |   |  |   |  |  |     |  |
| <b>VA</b>   | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br><i>James D. Parker</i>   |   |   |   |  |   |  |  |     |  |

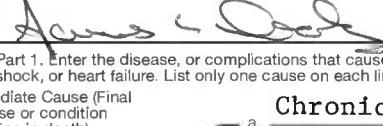
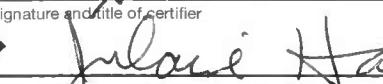
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15264

1 - For  
State  
Registrar

|   |  |  |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|---|---|--|--|--|--|--|---|--|--|--|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 1. Decedent's Name (First, Middle, Last)<br><b>Gloria Ann Keehan</b>   |  |  |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>28</b> , Year <b>2012</b>  |  |  | 3. Time of Death<br><b>2:05 P M</b>  |   |  |  |  |   |  |
|   |  | 4a. Facility Name (if not institution, give street and number)<br><b>Renaissance Gardens at Riderwood Village</b>  |  |  |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  |  | 4c. County of Death<br><b>P.G.</b>   |   |  |  |  |   |  |
|   |  | 5. Social Security Number<br><b>389-22-7868</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>85</b><br>Yrs.   |  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | 8. Date of Birth<br>Month <b>Feb.</b> Day <b>19</b> , Year <b>1927</b> |  | 9. Birthplace (State or Foreign Country)<br><b>IL</b> |  |  |  |   |  |
| <b>Funeral<br/>Director</b>   |  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>P.G.</b> 10c. City, Town or Location <b>Silver Spring</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>To Be Completed by Funeral Director</b>                                |  | 10e. Street and Number<br><b>3142 Gracefield Road, MG-605</b>  |  |  |   | 10f. Zip Code<br><b>20904</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                            |  |   |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b><br>Specify:           |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) <b>4</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |   |  | 16b. Kind of Business Industry<br><b>Education</b>   |  |  |  |   |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 17. Father's Name (First, Middle, Last)<br><b>Carl Francis Gilsinger</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Fair</b>  |  |  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Therese L. Shell/Daughter</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>212 Midsummer Circle, Gaithersburg, MD 20878</b>  |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   |  | Date<br><b>May 3, 2012</b>   |  |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>                      |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.</b><br><b>500 University Blvd. W, Silver Spring, MD 20901</b> |  |  |  |  |  |   |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |   |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 yrs.</b>  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | a. Due to (or as a consequence of):<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | b. Due to (or as a consequence of):<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  |  |   |   |  |  |  |  |  |   |  | <b>4 yrs.</b>  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | c. Due to (or as a consequence of):<br>  |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | d. _____   |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month <b>0</b> Day <b>0</b> Year <b>0000</b>  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  |  |  |  |   |   |  |  |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |   |  | 26. Place of Death (Check only one)<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                   |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  |  | 28a. Date of injury<br>(Month, Day, Year)   |   |  | 28b. Time of injury<br>M   |  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  | 28d. Describe how injury occurred  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |   |  |  |  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>Only one<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 29b. Signature and title of certifier<br>   |  |  | 29c. License number<br><b>R112633</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>7/30/12</b>  |  |  |  |   |  |  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Julaine Harding, CRNP</b> 3110 Gracefield Road, Silver Spring, MD 20904   |  |  |   |   |  |  |  |  |  |   |  |  |  |   |  |
| <b>State<br/>Registrar</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  |  | 32. Registrar's Signature<br>  |   |  |  |  |  |  |   |  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15265

1 - For  
State  
Registrar

|  |  |  |   |  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>NELL H. KILROY</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> Year <b>2012</b>  | 3. Time of Death<br><b>1:50 a M</b>  |   |  |  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Bradford Oaks Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |  | 4c. County of Death<br><b>Prince Georges</b>                  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-26-7976</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>88</b> Yrs.   | If Under 1 Year<br>Months      Days  | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 8, 1924</b> | 9. Birthplace (State or Foreign Country)<br><b>NC</b>      |  |  |  |
|  | Usual Residence of Decedent<br><b>MD Prince Georges</b>  |  | 10a. State      10b. County   |  |  |  | 10c. City, Town or Location<br><b>Forestville</b>             |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>7141 Donnell Pl. #C7</b>  |  |   |  | 10f. Zip Code<br><b>20747</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                   |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br><b>White</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>2 yrs</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b> |  |  | 16b. Kind of Business/Industry<br><b>Congressional</b>        |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles W. Hackney</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Thompson</b>   |  |   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Kleifges - Niece</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1900 Baton Dr. Vienna, VA. 22182</b>   |  |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>                             |  | Date<br><b>5-1-2012</b>  | 20c. Location - City or Town, State<br><b>Suitland, MD</b>    |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Dolores L Woods</b>  |  |   |  | 22. Name and Address of Facility<br><b>Marshall-March Funeral Home of Maryland<br/>4308 Suitland Rd. Suitland, MD 20746</b>  |  |   |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Arteriosclerotic Heart Disease</b>  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |  |
|  | a. Due to (or as a consequence of):<br><b>Arteriosclerotic Heart Disease</b>   |  |   |  |  |  |   |  |  |  |  |
|  | b. Due to (or as a consequence of):  |  |   |  |  |  |   |  |  |  |  |
|  | c. Due to (or as a consequence of):  |  |   |  |  |  |   |  |  |  |  |
|  | d. _____   |  |   |  |  |  |   |  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month      Day      Year             |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |  |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |  |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |  |  |  |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                             |  |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>William T. Tanner</b>  |  | 29c. License number<br><b>D35206</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4-30-2012</b>       |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William T. Tanner, MD 11701 Livingston Road, Fort Washington, MD 20744</b>  |  |   |  |  |  |   |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br><b>James A. Parker</b>   |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death  
To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15266

For  
State  
Registrar

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Jane Kennedy</b>   |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>2012</b>                   | 3. Time of Death<br>0023 AM                                   |  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Union Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   | 4c. County of Death<br><b>Cecil</b>  |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-28-5965</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. <b>81</b>  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>                              | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>                                     | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT 28, 1930</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |
| To Be Completed by Funeral Director                                | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>Elkton</b>   |   |   |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>417 Appleton Road</b>   |   | 10f. Zip Code<br><b>21921</b>   |   |  | 10g. Citizen of What Country?<br><b>United States</b>         |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>Elementary/Secondary (0-12)</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>Toll Sergeant</b>   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Caucasian</b>   |  |   |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>  | 16b. Kind of Business Industry<br><b>State Highway Administration</b>   |   |  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Z. Stoppel</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louetta A. Oldham</b> |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah A. Kennedy/Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 Appleton Road, Elkton, MD 21921</b>   |   |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Kreuter His Esmeus</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bay View Cemetery</b>  |   | Date <b>May 10, 2012</b>   | 20c. Location - City or Town, State<br><b>Bay View, MD</b>    |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Kreuter His Esmeus</b>   |   | 22. Name and Address of Facility <b>Hicks Home for Funerals, P.A.</b><br><b>103 W. Stockton Street, Elkton, MD 21921</b>  |   |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>HYPERTENSION</b><br>Due to (or as a consequence of):<br><b>HYPERLIPIDEMIA</b><br>Approximate Interval Between Onset and Death<br><b>Hours</b>   |   |   |   |  |   |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Years</b>   |   |   |   |  |   |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                             |  |  |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br><b>S MD</b>   |   | 29c. License number<br><b>D0047711</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 7, 2012</b>     |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID GAR-EL 304-306 NORTH STREET SUITE #3 ELKTON MARYLAND 21921</b>  |   |   |   |  |   |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b>  |   | 32. Registrar's Signature<br><b>Leanne A. Parker</b>  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15267

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
per 1st. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Allan Lowry</b>   |  |   | 2. Date of Death<br>Month: April Day: 26 Year: 2012   | 3. Time of Death<br>5:37 A M  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   |
| 5. Social Security Number<br><b>220-50-0102</b>  |  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63</b><br>Yrs.   |
| 8. If Under 1 Year<br>Months:      Days:      Hours:      Min:   |  |   | 9. Date of Birth<br>(Month, Day, Year)<br><b>4/30/1948</b>  | 10. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |
| 10a. State<br><b>Maryland</b>  |  |   | 10b. County<br><b>Anne Arundel</b>  |   |
| 10c. City, Town or Location<br><b>Annapolis</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>1562 St. Margarets Road</b>   |  |   | 10f. Zip Code<br><b>21409</b>   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>  |   | 16b. Kind of Business/Industry<br><b>Service Station Owner</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>James A. Lowry</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Crouch</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline Wooster - Daughter</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>531 Ridge Road, Annapolis, MD 21401</b> |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem Gardens</b>                                 | Date<br><b>5/1/12</b>   |
| 20c. Location - City or Town, State<br><b>Timonium, MD</b>   |  |   |   |   |
| 21. Signature of Funeral Service Licensee<br><b>► Myelin I. Robert</b>   |  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home<br/>147 Duke of Gloucester St, Annapolis, MD 21401</b>                   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b>  |  |   |   |   |
| Approximate Interval Between Onset and Death   |  |   |   |   |
| a. Due to (or as a consequence of):<br><b>Sepsis</b>   |  |   |   |   |
| b. Due to (or as a consequence of):  |  |   |   |   |
| c. Due to (or as a consequence of):  |  |   |   |   |
| d. _____   |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rhabdomyolysis</b>  |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury   | 28c. Injury at work?<br>M <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |
| 29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |
| 29b. Signature and title of certifier<br><b>► Stephen Olexo, M.D.</b>  |  |   |   |   |
| 29c. License number<br><b>DS8510</b>   |  |   |   |   |
| 29d. Date signed (Month, Day, Year)<br><b>04/26/12</b>   |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen Olexo, M.D., ABIMC</b>  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 27 2012</b>  |  |   |   |   |
| 32. Registrar's Signature<br><b>Anna S. Parker</b>   |  |   |   |   |

ORIGINAL

CHS  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15268

For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lawrence S. Lewin</b>                                  |  |  | 2. Date of Death<br>Month April Day 29 Year 2012           |  |  | 3. Time of Death<br>3:50P.M.             |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>5610 Wisconsin Avenue, #1103</b> |  |  | 4b. City, Town, or Location of Death<br><b>Chevy Chase</b> |  |  | 4c. County of Death<br><b>Montgomery</b> |  |

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial slip.

Division of Vital Records, P.O. Box 68760

25+

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 5. Social Security Number<br><b>117-28-2617</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>74 Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>Month Apr Day 23 Year 1938        | 9. Birthplace (State or Foreign Country)<br><b>Queens, New York</b>                            |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Chevy Chase</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5610 Wisconsin Avenue, #1103</b>   |  |  | 10f. Zip Code<br><b>20815</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b> |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1959-1962</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                 |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>5+</b>                         |  | 16b. Kind of Business Industry<br><b>CEO</b>   |  |   | 16c. Date of Death<br><b>5/1/2012</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jerome Lewin</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Duckoff</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marion Lewin -wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5610 Wisconsin Avenue, #1103 Chevy Chase, MD 20815</b> |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gdn. of Remembrance</b>   |  | Date   | 20c. Location - City or Town, State<br><b>Clarksburg, Maryland</b> |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, PA<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>                                     |  |  |  |   |  |  |

|  |  |  |  |  |  |                                   |  |  |  |  |
|--|--|--|--|--|--|-----------------------------------|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |  |  |                                   |  | Approximate Interval Between Onset and Death   |  |  |
| <p>a. <b>Liver Failure</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Hepatocellular Carcinoma</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |  |  |  |  |                                   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown    |  |  |  |                                   |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes; Atherosclerotic Cardiovascular Disease</b>  |  |  |  |  |  |                                   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |                                   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |  |  |
|  |  |  |  |  |  |                                   |  |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>7663</b>   |  |  |  |                                   |  | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ace Lipson, M.D. 1120 19th Street, N.W., #200 Washington, DC 20036</b>  |  |  |  |  |  |                                   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br><b>Leanne J. Farrel</b>   |  |  |  |                                   |  |  |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

Nelson Enrique Landaverde-Alas

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15269

1- For State  
Registrar**Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1110 hrs |
| <b>Nelson Enrique Landaverde-Alas</b>    | April 24, 2012                     |                              |

|   |  |   |
|---|--|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>722 Shelby Drive</b> | 4b. City, Town, or Location of Death<br><b>Oxon Hill</b> | 4c. County of Death<br><b>Prince George's</b> |
|---|--|---|

**Funeral  
Director**

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 5. Social Security Number<br><b>none</b> | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>45</b> | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>07/15/1967</b> | 9. Birthplace (State or Foreign Country)<br><b>EL Salvador</b> |
|  |   | Yrs.  |   |  |  |

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, MD 21215-0036**Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executedwithin 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit**To Be Completed by Funeral Director****Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |   |  |  |                                |
|---|---|--|--|--------------------------------|
| 10a. State<br><b>MD</b>   | 10b. County<br><b>PG</b>  | 10c. City, Town or Location<br><b>Oxon Hill</b>  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                        |                                |
| 10e. Street and Number<br><b>722 Shelby DR,</b>   |   | 10f. Zip Code<br><b>22045</b>  | 10g. Citizen of What Country?<br><b>El Salvador</b>  |                                |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No specify:<br>Specify: <b>White</b> | 14. Race - American Indian, Black, White, etc.   |                                |
| Elementary/Secondary (0-12)<br><b>9 TH</b>  | College (1-4 or 5+)   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Construction</b>   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b> | 16b. Kind of Business/Industry |
| 17. Father's Name (First, Middle, Last)<br><b>Aristides Landaverde Mata</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Cristina Alas</b>  |  |                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sister-in-law</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Elissette Figueroa de Monge 1403 Kentucky Ave. woodbridge VA 22191</b>   |  |                                |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Family Cemetery</b>  | Date<br><b>5/8/2012</b>  | 20c. Location - City or Town, State<br><b>El Salvador</b>  |                                |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><b>Wardie C. Bacon cc0361</b>  | 22. Name and Address of Facility W.H. Bacon F.H.<br><b>3447 14TH ST. NW. WA, DC 20010</b>   |  |  |                                |

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                  | Approximate Interval Between Onset and Death  |   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Carbon Monoxide Toxicity</b><br>Due to (or as a consequence of):   |                                  |   |   |
| b.<br>Due to (or as a consequence of):  |                                  |   |   |
| c.<br>Due to (or as a consequence of):  |                                  |   |   |
| d.<br>_____   |                                  |   |   |
| <input type="checkbox"/> UNPENDED   | <input type="checkbox"/> AMENDED |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |                                  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |

|  |   |   |   |
|--|---|---|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>_____ |   |
|  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury<br>Month Day Year<br><b>FOUND: Apr 24, 2012</b>   | 28b. Time of Injury<br>FOUND: 1003 hrs  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Exposure to home furnace exhaust |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) <b>Single Family Home</b>   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>722 Shelby Drive, Oxon Hill, MD</b>  |   |

|   |
|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

|  |  |  |
|--|--|--|
| 29b. Signature and title of certifier<br><b>Carole Allan</b> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>April 25, 2012</b> |
|--|--|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b> | 32. Registrar's Signature<br><b>Carole Allan</b> |
|---|--|

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15270

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |  |                                |  |                                     |   |   |  |  |
|--|--|--|--|--------------------------------|--|-------------------------------------|---|---|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)   |  |                                | 2. Date of Death   |                                     |   | 3. Time of Death  |  |  |
|  |  | Odessa Darlene Lanham  |  |                                | Month May 6 Day 2012 Year  |                                     |   | 3. Time of Death 1750 P M   |  |  |
| Physician/<br>Medical<br>Examiner  |  | 4a. Facility Name (if not institution, give street and number)   |  |                                | 4b. City, Town, or Location of Death   |                                     |   | 4c. County of Death   |  |  |
|  |  | Union Hospital   |  |                                | Elkton   |                                     |   | Cecil   |  |  |
| Funeral<br>Director  |  | 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.                    | 8. Date of Birth  | 9. Birthplace (State or Foreign Country)  |  |  |
|  |  | 218-40-1702  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 71 Yrs.                        | Months   | Days                                | Month Day Year May 2, 1941  | Massachusetts   |  |  |
| Usual Residence of Decedent  |  | 10a. State   | 10b. County  | 10c. City, Town or Location    |  |                                     | 10d. Inside City Limits   |   |  |  |
|  |  | Maryland   | Cecil  | Elkton                         |  |                                     | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
| To Be Completed by Funeral Director  |  | 10e. Street and Number   |  |                                | 10f. Zip Code  |                                     |   | 10g. Citizen of What Country?   |  |  |
|  |  | 255 Sycamore Road  |  |                                | 21921  |                                     |   | United States   |  |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?  |  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)                                   |                                     |   | 14. Race - American Indian, Black, White, etc. Specify: White   |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                     |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  |                                | 16b. Kind of Business Industry   |                                     |   |   |  |  |
| Elementary/Secondary (0-12)  |  | College (1-4 or 5+)  |  |                                | Licensed Practical Nurse   |                                     |   | Health Care   |  |  |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |                                |  |                                     |   |   |  |  |
| Russell Blake  |  | Arthur D. Lanham/Husband   |  |                                | Mary Lou Young   |                                     |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |                                |  |                                     |   |   |  |  |
|  |  | 255 Sycamore Road, Elkton, MD 21921  |  |                                |  |                                     |   |   |  |  |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, cemetery or other place)  |  |                                | Date   | 20c. Location - City or Town, State |   |   |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | North East Methodist Cemetery  |  |                                | May 11, 2012   | North East, MD                      |   |   |  |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility   |  |                                | Hicks Home for Funerals, P.A.  |                                     |   |   |  |  |
| <i>Kristen Hicks Esmon</i>   |  | 103 W. Stockton Street, Elkton, MD 21921   |  |                                |  |                                     |   |   |  |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  | Approximate Interval Between Onset and Death   |  |                                |  |                                     |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | <i>Cardiomyopathy</i>  |  |                                |  |                                     |   | <i>Unknown</i>  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <i>Coronary Artery Disease</i>   |  |                                |  |                                     |   | <i>Years</i>  |  |  |
| a. Due to (or as a consequence of):  |  |  |  |                                |  |                                     |   |   |  |  |
| b. Due to (or as a consequence of):  |  |  |  |                                |  |                                     |   |   |  |  |
| c. Due to (or as a consequence of):  |  |  |  |                                |  |                                     |   |   |  |  |
| d. _____   |  |  |  |                                |  |                                     |   |   |  |  |
| IF FEMALE:   |  | 23c. If yes, outcome of pregnancy  |  |                                | 23d. Date of delivery  |                                     |   |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>g <input type="checkbox"/> Unknown   |  | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |                                | Month Day Year   |                                     |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |                                | 23e. Did tobacco use contribute to the cause of death?   |                                     |   |   |  |  |
|  |  |  |  |                                | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                     |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |  |                                | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |                                     |   | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 27. Manner of Death  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury            | M  | 28c. Injury at work?                | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No            | 28d. Describe how injury occurred   |  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  |  |  |                                |  |                                     |   |   |  |  |
| 29a. Certifier<br>(Check only one)   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                |  |                                     |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |  |  |
| 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |                                |  |                                     |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Sachdev S MD</i>   |  |  |  |                                | 29c. License number<br><i>D0083322</i>   |                                     |   | 29d. Date signed (Month, Day, Year)<br><i>5.7.2012</i>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |  |  |                                |  |                                     |   |   |  |  |
| <i>S. S Sachdev MD, 1264 E High ST, Elkton MD 21921</i>  |  |  |  |                                |  |                                     |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 14 2012</i>  |  | 32. Registrar's Signature<br><i>Leanne J. Parker</i>   |  |                                |  |                                     |   |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15271

1- For  
State  
Registrar**Physician/  
Medical  
Examiner****Funeral  
Director**

To Be Completed by Funeral Director

Murray, Linda M086521  
Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

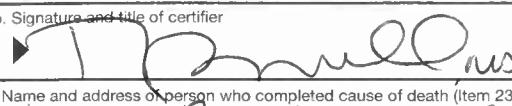
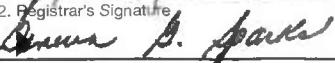
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

BA-8

|   |                        |   |   |   |   |
|---|------------------------|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)  |                        | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>2:45 PM   |   |
| Linda Louise Murray   |                        | April 24 2012   |   |   |   |
| 4a. Facility Name (if not institution, give street and number)  |                        | 4b. City, Town, or Location of Death  |   | 4c. County of Death   |   |
| Civista Medical Center  |                        | La Plata  |   | Charles   |   |
| 5. Social Security Number   |                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>68 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours   |
| 213-44-4755<br>Usual Residence of Decedent  |                        |   |   | Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>10-07-1943                                |
| 10a. State<br>Maryland  | 10b. County<br>Charles | 10c. City, Town or Location<br>La Plata   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br>403 Butternut Court   |                        | 10f. Zip Code<br>20646  |   |   | 10g. Citizen of What Country?<br>United States                                      |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   |
|   |                        |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |                        | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Administration   |   | 16b. Kind of Business/Industry<br>Health Care   |   |
| 17. Father's Name (First, Middle, Last)<br>Thomas L. Murray   |                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gladys M. Murphy   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Janet Faherty/Executor  |                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6499 Aura Dr. La Plata, Maryland 20646   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart  |   | Date<br>04-28-2012  | 20c. Location - City or Town, State<br>La Plata, Maryland                           |
| 21. Signature of Funeral Service Licensee<br>  |                        | 22. Name and Address of Facility<br>Arehart-Echols Funeral Home, P.A.<br>M01458 211 St. Mary's Ave. La Plata, MD 20646  |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |                        |   |   |   |   |
| <p>a. <u>Hepatocellular Carcinoma</u><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |                        |   |   |   |   |
| Approximate Interval Between Onset and Death  |                        |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |                        | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                        |   |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                        |   |   |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                        |   |   |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                        |   |   |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                        | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |                        | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred   |
|   |                        | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                        |   |   |   |   |
| 29b. Signature and title of certifier<br>  |                        | 29c. License number<br>D12034   |   | 29d. Date signed (Month, Day, Year)<br>April 24, 2012   |   |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br>Rebecca Powell MD 5 Garrett Ave La Plata, MD 20646  |                        |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br>APR 27 2012  |                        | 32. Registrar's Signature<br>  |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15272

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

ANTHONY

Mason

2. Date of Death

Month  
04

Day  
24

Year  
12

3. Time of Death

10:10 AM

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

5226 Sands Road

4b. City, Town, or Location of Death  
Lothian

4c. County of Death  
Anne Arundel

Funeral  
Director

5. Social Security Number

215-56-9279

6. Sex

M

F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

8/13/1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

Yes  No

10e. Street and Number

5226 Sands Road

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bricklayer

16b. Kind of Business/Industry  
Self-employed

17. Father's Name (First, Middle, Last)

Blondell Samuel Mason

18. Mother's Name (First, Middle, Maiden Surname)

Pinkie Broom

19a. Informant's Name/Relationship (Type, Print)

Valerie Mason/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5226 Sands Rd. Lothian, MD 20711

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chelt. Vet. Cem.

Date

4/30/2012 Cheltenham, MD

21. Signature of Funeral Service Licensee

► Gladys A. Sevell

22. Name and Address of Facility Sewell Funeral Home, P.A.

1451 Dares Beach Rd. Prince Fred., MD 20678

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LIVER FAILURE

Approximate Interval Between Onset and Death DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient  ER/Outpatient

3  DOA

Other:

4  Nursing Home

5  Residence

6  Other (Specify)

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  
 Homicide

28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?  
 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Michael J. LaPenta

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

April 25 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LAPENTA MD 441 DEFENSE Hwy, ANAPOLIS MD 21401

31. Date filed (Month, Day, Year)

APR 27 2012

32. Registrar's Signature

► Michael J. LaPenta

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15273

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
Christa Anna Maier2. Date of Death  
Month April Day 26 Year 2012  
8:58 A M

permit Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|   |  |   |   |  |                          |                                |  |  |  |
|---|--|---|---|--|--------------------------|--------------------------------|--|--|--|
| 4a. Facility Name (if not institution, give street and number)<br>Calvert County Nursing Center   |  |   |   | 4b. City, Town, or Location of Death<br>Prince Frederick   |                          |                                |  | 4c. County of Death<br>Calvert   |  |
| 5. Social Security Number<br>212-82-4159  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>75 Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>02/06/1937 | 9. Birthplace (State or Foreign Country)<br>Germany              |  |  |
| Usual Residence of Decedent<br>10a. State Maryland 10b. County Calvert 10c. City, Town or Location Prince Frederick   |  |   |   |  |                          |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>85 Hospital Road  |  |   |   | 10f. Zip Code<br>20678   |                          |                                | 10g. Citizen of What Country?<br>United States                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>1          |   | 16b. Kind of Business Industry<br>Hairdresser  |                          |                                | 16c. Kind of Business Industry<br>Beautician                     |  |  |
| 17. Father's Name (First, Middle, Last)<br>Fritz Bassfeld   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Berta unknown   |                          |                                |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Angelika McMann - daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Walker Drive Sinsbury CT 06070  |                          |                                |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Funeral Service   |                          |                                | 20c. Date of Disposition<br>04/27/2012                           | 20c. Location - City or Town, State<br>Alexandria Virginia                                     |  |
| 21. Signature of Funeral Service Licensee<br>► Brawns   |  |   |   | 22. Name and Address of Facility Rausch Funeral Home PA<br>4405 Broomes Is. Rd. Port Republic, MD 20676  |                          |                                |  |  |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

Funeral  
Director

|   |  |  |  |  |  |  |  |  |                                   |
|---|--|--|--|--|--|--|--|--|-----------------------------------|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown                    |  | 23d. Date of delivery<br>Month Day Year  |  | Approximate Interval Between Onset and Death                                     |                                   |
| 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23g. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 23h. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No            |  |  |                                   |
| 24a. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |                                   |
| 25. Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |                                   |
| 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>► David Gallatin MD   |  | 29c. License number<br>DS949   |  | 29d. Date signed (Month, Day, Year)<br>4/27/12   |  |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David Gallatin 10 Hospital Rd Suite 310, Prince Frederick, MD 20678   |  |  |  |  |  |  |  |  |                                   |
| 31. Date filed (Month, Day, Year)<br>APR 30 2012  |  | 32. Registrar's Signature<br>Lorraine S. Parker  |  |  |  |  |  |  |                                   |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15274

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |   |  |   |  |   |   |   |
|--|--|---|--|---|--|---|---|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Virginia Mary Mackey</b>                        |   |  |   |  | 2. Date of Death<br>Month April Day 27 Year 2012                |   | 3. Time of Death<br>6:10 PM   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>7690 Old Bayside Road</b> |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Chesapeake Beach</b> |   | 4c. County of Death<br><b>Calvert</b>                                   |
| Funeral<br>Director  | 5. Social Security Number<br><b>050-36-3405</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>68</b><br>Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>09-25-1943</b> | 9. Birthplace (State or Foreign Country)<br><b>New York</b>             |
|  | Usual Residence of Decedent<br><b>MD Calvert</b>   |   | 10a. State<br>10b. County  |   |  | 10c. City, Town or Location<br><b>Chesapeake Beach</b>          |   |   |
| 10e. Street and Number<br><b>7690 Old Bayside Road</b>   |  |   |  |   | 10f. Zip Code<br><b>20732</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                 |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Restaurant Manager</b>         |  |   | 16b. Kind of Business/Industry<br><b>Restaurant</b>  |   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Joseph Carroll</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Gladys Cade</b>  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William F. Mackey, Sr., Spouse</b>  |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 705, Chesapeake Beach, MD 20732</b>   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>So. Memorial Gardens</b> |  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date  | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>William R. Grier</b>   |  |   |  |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.</b><br><b>8325 Mt. Harmony Lane, Owings, MD 20736</b>   |   |   |   |

|  |  |   |  |  |
|--|--|---|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death |
| {  |  | a. <b>Lung cancer metastases</b><br>Due to (or as a consequence of):  |  | <b>months</b>                                |
| {  |  | b. <b>Colon cancer metastases</b><br>Due to (or as a consequence of):   |  | <b>years</b>                                 |
| {  |  | c. _____<br>Due to (or as a consequence of):  |  |  |
| {  |  | d. _____<br>Due to (or as a consequence of):  |  |  |

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____ |  |  | 23d. Date of delivery<br>Month Day Year |  |  |
|--|--|---|--|--|---|--|--|

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M               | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                            |  |  |
| 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Mark R. Reed</b>   |  |   |  | 29c. License number<br><b>00059061</b> |  | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shanti Patel 110 Hospital Rd, Prince Frederick MD 20678</b>   |  |   |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  |  |  |
| 32. Registrar's Signature<br><b>Shanti Patel</b>   |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15275

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |                                     |                                |   |
|---|--|---|--|-------------------------------------|--------------------------------|---|
| 1. Decedent's Name (First, Middle, Last)  | 2. Date of Death   |   |  |                                     | 3. Time of Death               |   |
| JAMES R. MARTIN   | Month Day Year   |   |  |                                     | Year M                         |   |
| 4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location of Death   |   |  |                                     | 4c. County of Death            |   |
| 1400 Fenwick Lane, #112   | Silver Spring  |   |  |                                     | Montgomery                     |   |
| 5. Social Security Number   | 6. Sex   | 7. Age (In yrs. last birthday)  | If Under 1 Year  | If Under 24 Hrs.                    | 8. Date of Birth               | 9. Birthplace (State or Foreign Country)                            |
| 220-42-0012   | <input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 68 Yrs.   | Months   | Days                                | Hours Min.                     | 03/19/1944 MD   |
| Usual Residence of Decedent   |  |   |  |                                     |                                |   |
| 10a. State  | 10b. County  | 10c. City, Town or Location   |  |                                     |                                | 10d. Inside City Limits   |
| MD  | Montgomery   | Silver Spring   |  |                                     |                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number  | 10f. Zip Code  |   |  |                                     | 10g. Citizen of What Country?  |   |
| 1400 Fenwick Land, #112   | 20910  |   |  |                                     | USA                            |   |
| 11. Marital Status  | 12. Was Decedent Ever in U.S. Armed Forces?  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     |                                | 14. Race - American Indian, Black, White, etc.                      |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |                                     |                                | Specify: Black  |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |                                     | 16b. Kind of Business Industry |   |
| Elementary/Secondary (0-12)<br>9th  |  | College (1-4 or 5+)<br>Laborer  |  |                                     | Lawn Maintenance               |   |
| 17. Father's Name (First, Middle, Last)   | 18. Mother's Name (First, Middle, Maiden Surname)  |   |  |                                     |                                |   |
| Leonard Martin  | Lillian Virginia Davis   |   |  |                                     |                                |   |
| 19a. Informant's Name/Relationship (Type, Print)  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)          |   |  |                                     |                                |   |
| Evelyn Genies/sister  | 15015 Seneca Road, Germantown, MD 20874  |   |  |                                     |                                |   |
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                 |   | Date   | 20c. Location - City or Town, State |                                |   |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | Ardent Cremation Sv  |   | 04/23/2012   | Hanover, MD                         |                                |   |
| 21. Signature of Funeral Service Licensee   | 22. Name and Address of Facility   |   |  |                                     |                                |   |
| George R. Snowden   | Snowden Funeral Home<br>246 N. Washington St, Rockville, MD 20850                                      |   |  |                                     |                                |   |

Physician  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial license.

Division of Vital Records, P.O. Box 68760

|  |  |   |                     |  |
|--|--|---|---------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                     | Approximate Interval Between Onset and Death   |
| <p>a. Due to (or as a consequence of):<br/><br/>My patient was due to cardiovascular disease DM</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |                     |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown     |                     | 23d. Date of delivery<br>Month Day Year  |
|  |  |   |                     |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DODA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                     | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | M   |                     | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                     |  |
| 29b. Signature and title of certifier<br>John D. Becker MD DMS   |  | 29c. License number<br>D00428   |                     | 29d. Date signed (Month, Day, Year)<br>Apr 25 2012   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Teresa GREENE, MD DMS  |  | 31. Date filed (Month, Day, Year)<br>MAY 01 2012  |                     | 32. Registrar's Signature<br>Leanne J. Pace  |
|  |  |   |                     |  |
|  |  |   |                     |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15276

## Certificate of Death

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

James Messick

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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## Division of Vital Records, P.O. Box 68760

|  |  |   |  |                                |  |  |   |  |
|--|--|---|--|--------------------------------|--|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)  |  |                                | 2. Date of Death   |  | 3. Time of Death  |  |
|  |  | James Dennis Messick  |  |                                | Month Day Year<br>04 - 30 - 2012   |  | Reg. No.  |  |
| Physician/<br>Medical<br>Examiner                                  |  | 4a. Facility Name (if not institution, give street and number)  |  |                                | 4b. City, Town, or Location of Death   |  | 4c. County of Death   |  |
|  |  | Coastal Hospice at the Lake   |  |                                | Salisbury  |  | Wicomico  |  |
| Funeral<br>Director  |  | 5. Social Security Number   | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year) | 9. Birthplace (State or Foreign Country)  |  |
|  |  | 216-44-8419   | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 65 Yrs.                        |  | 12/23/1946                             | OH  |  |
| To Be Completed by Funeral Director                                |  | Usual Residence of Decedent   |  |                                | 10d. Inside City Limits  |  |   |  |
|  |  | 10a. State  | 10b. County  | 10c. City, Town or Location    | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|  |  | MD  | Worcester  | Berlin                         |  |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 10e. Street and Number  |  |                                | 10f. Zip Code  | 10g. Citizen of What Country?          |   |  |
|  |  | 36 Anchor Way Dr.   |  |                                | 21811  | USA                                    |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 11. Marital Status  |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  |  | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  |                                |  |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)  |  |                                | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business Industry  |  |
|  |  | Elementary/Secondary (0-12) 12  |  |                                | College (1-4 or 5+) Realtor  |  | Real Estate   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 17. Father's Name (First, Middle, Last)   |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)  |  |   |  |
|  |  | Isaac J. Messick  |  |                                | Marguerite Gordon  |  |   |  |
| To Be Completed by Funeral Director                                |  | 19a. Informant's Name/Relationship (Type, Print)  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |
|  |  | Jeff Messick/son  |  |                                | 36 Anchor Way Drive Berlin, MD 21811   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 20a. Method of Disposition  |  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date                                   | 20c. Location - City or Town, State   |  |
|  |  | 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                                | First State Crem.  | 5/2/12                                 | Hillsboro, De   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 21. Signature of Funeral Service Licensee   |  |                                | 22. Name and Address of Facility   |  |   |  |
|  |  | ▶ Jim MacLeod   |  |                                | Burbage Funeral Home<br>108 William St., Berlin, MD 21811  |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                |  |  |   |  |
|  |  | Immediate Cause (Final disease or condition resulting in death)   |  |                                |  |  |   |  |
|  |  | a. Due to (or as a consequence of): COLON CARCINOMA   |  |                                |  |  |   |  |
|  |  | b. Due to (or as a consequence of):   |  |                                |  |  |   |  |
|  |  | c. Due to (or as a consequence of):   |  |                                |  |  |   |  |
|  |  | d. Due to (or as a consequence of):   |  |                                |  |  |   |  |
| To Be Completed by Funeral Director                                |  | Approximate Interval Between Onset and Death  |  |                                |  |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | IF FEMALE:  |  |                                | 23c. If yes, outcome of pregnancy  |  |   | 23d. Date of delivery  |
|  |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |                                | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   | Month Day Year   |
| To Be Completed by Physician/Medical Examiner                      |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                |  |  |   |  |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                |  |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                |  |  |   |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                |  |  |   |  |
| To Be Completed by Funeral Director                                |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                | 26. Place of Death (Check only one)  |  |   |  |
|  |  | Hospital:   |  |                                | 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   | Other:                                 | 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)  | HOSPIC   |
| Physician/<br>Medical Examiner                                     |  | 27. Manner of Death   |  |                                | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury                    | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |
|  |  | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |                                | M  |  |   |  |
| To Be Completed by Physician/Medical Examiner                      |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|  |  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                |  |  |   |  |
| To Be Completed by Funeral Director                                |  | 29b. Signature and title of certifier   |  |                                | 29c. License number  |  |   | 29d. Date signed (Month, Day, Year)  |
|  |  | ▶ S. Hansen Wares P.O. Box 1733 Salisbury MD 21802  |  |                                | D005840  |  |   | 05/01/12   |
| To Be Completed by Physician/Medical Examiner                      |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |                                |  |  |   |  |
|  |  | 31. Date filed (Month, Day, Year)   |  |                                | 32. Registrar's Signature  |  |   |  |
|  |  | MAY 01 2012   |  |                                | Anna S. Parker   |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15277  
Certificate of Death1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

DN 10

State  
Registrar

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Shirley McGall Polhemus</b>   |   |   | 2. Date of Death<br>Month 4 Day 28 Year 2012   | 3. Time of Death<br>3:30 PM  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>37 Fountain Dr. Unit 4A</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Ocean City</b>  | 4c. County of Death<br><b>Worcester</b>  |  |
|  |  | 5. Social Security Number<br><b>143-24-5484</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month Day Year)<br><b>2/10/1931</b>                         | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                        |
|  |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Worcester</b>   |   |   | 10c. City, Town or Location<br><b>Ocean City</b>   |  |  |
|  |  | 10e. Street and Number<br><b>37 Fountain Dr. Unit 4A</b>   |   |   | 10f. Zip Code<br><b>21842</b>  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>white</b>   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Milton McGall</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Gilbert</b>  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Polhemus/husband</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>37 Fountain Dr., Unit 4A, Ocean City, MD 21842</b>  |  |  |  |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>First State Crem.</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>First State Crem.</b>  | Date<br><b>5/1/2012</b>  | 20c. Location - City or Town, State<br><b>Millsboro, DE</b>                      |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>► Jim MacLeod</b>  |   | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St., Berlin, MD 21811</b>   |  |  |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   |   | Approximate Interval Between Onset and Death   |  |  |
|  |  | <p>a. <b>Metastatic Colorectal Cancer</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |   |   |  |  |  |
|  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |  |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year  |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |
|  |  |  |   |   | <p>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|  |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |
|  |  | 29b. Signature and title of certifier<br><b>► David Coughlin MD</b>  |   | 29c. License number<br><b>D26278</b>  | 29d. Date signed (Month, Day, Year)<br><b>7-30-12</b>  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID COUGHLIN MD COASTAL HOSPICE PO BOX 1733 Solomons, MD 21808</b>  |   |   |  |  |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |   | 32. Registrar's Signature<br><b>Renata A. Parker</b>  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item 1 - For State Registrar #18, per F.Home, 5/7/12, E.T. Certificate of Death WCHD

Reg. No.

2012 15278

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

*Raymond Pugh*  
Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State  
Registrar

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Hour Minute AM/PM  |  |
| Raymond Alan Pugh, Sr.  |  | 04 30 2012  |   | 4:07 PM  |  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |  |
| <i>Coastal Hospice at the Lake</i>  |  | <i>Salisbury</i>  |   | <i>Nicomico</i>  |  |
| 5. Social Security Number   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>9/7/1930   |
| Usual Residence of Decedent<br>10a. State<br>MD   |  | 10b. County<br>Worcester  |   | 10c. City, Town or Location<br>Berlin  |  |
| 10e. Street and Number<br>334 Ocean Parkway   |  | 10f. Zip Code<br>21811  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br>white |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>5+   |   | 16b. Kind of Business/Industry<br>Accountant<br>U.S. Government  |  |
| 17. Father's Name (First, Middle, Last)<br>Stanley John Pugh  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Caroline Dalton<br>Maryl Caroline Dalton  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Beverly Pugh / wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>334 Ocean Parkway, Berlin, MD 21811  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>First State Crem.   |   | Date<br>5/2/12   | 20c. Location - City or Town, State<br>Millsboro, DE |
| 21. Signature of Funeral Service Licensee<br><i>Beverly Pugh</i>  |  | 22. Name and Address of Facility<br>Burbage Funeral Home<br>334 Ocean Parkway, Berlin, MD 21811   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |   |  |  |
| <p>a. <i>BLADDRL CARCINOMA</i><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown     |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Hospice</i> |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred                    |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |  |
| 29c. License number<br><i>D0058410</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>04/30/12</i>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Caroline Dalton 1733 Salisbury MD 21802</i>  |  | 31. Date filed (Month, Day, Year)<br><i>MAY 01 2012</i>   |   |  |  |
| 32. Registrar's Signature<br><i>Caroline A. Dalton</i>  |  |   |   |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15279

1- For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |   |  |   |  |   |  |                                     |  |                                     |  |
|--|--|---|--|---|--|---|--|-------------------------------------|--|-------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Martha Peritz</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 30, 2012</b>   | 3. Time of Death<br><b>2:35A M</b>   |   |  |   |  |                                     |  |                                     |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  |   |  |   |  |                                     |  |                                     |  |
| 4c. County of Death<br><b>Montgomery</b>   |  |   |  |   |  |   |  |                                     |  |                                     |  |
| 5. Social Security Number<br><b>183-50-5059</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88 Yrs.</b>   |   |  |   |  |                                     |  |                                     |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct 30, 1923</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Czechoslovakia</b>   |  |   |  |   |  |                                     |  |                                     |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   |  |   |  |                                     |  |                                     |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |   |  |                                     |  |                                     |  |
| 10e. Street and Number<br><b>1928 Westchester Dr</b>   |  | 10f. Zip Code<br><b>20902</b>   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |                                     |  |                                     |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |   |  |   |  |                                     |  |                                     |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |   |  |                                     |  |                                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>Adolph Rosenwasser</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Schreiber</b>  |  |   |  |   |  |                                     |  |                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Leslie Peritz/Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1928 Westchester Dr, Silver Spring, MD 20902</b>  |  |   |  |   |  |                                     |  |                                     |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rosenberg Cemetery</b>   | 20c. Date<br><b>May 2, 2012</b>  |   |  |   |  |                                     |  |                                     |  |
| 21. Signature of Funeral Service Licensee<br><b>► Carl Danner no1024</b>   |  | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.<br><b>11800 New Hampshire Ave, Silver Spring, MD 20904</b>  |  |   |  |   |  |                                     |  |                                     |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |   |  |   |  |                                     |  |                                     |  |
| <table border="1"> <tr> <td>a. Due to (or as a consequence of):<br/><b>Respiratory Failure</b></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of):<br/><b>Pneumonia</b></td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>  |  |   |  | a. Due to (or as a consequence of):<br><b>Respiratory Failure</b> | Approximate Interval Between Onset and Death | b. Due to (or as a consequence of):<br><b>Pneumonia</b> |  | c. Due to (or as a consequence of): |  | d. Due to (or as a consequence of): |  |
| a. Due to (or as a consequence of):<br><b>Respiratory Failure</b>  | Approximate Interval Between Onset and Death |   |  |   |  |   |  |                                     |  |                                     |  |
| b. Due to (or as a consequence of):<br><b>Pneumonia</b>  |  |   |  |   |  |   |  |                                     |  |                                     |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |   |  |                                     |  |                                     |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |   |  |                                     |  |                                     |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year  |   |  |   |  |                                     |  |                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b>   |  |   |  |   |  |   |  |                                     |  |                                     |  |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |                                     |  |                                     |  |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |                                     |  |                                     |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |  |   |  |   |  |                                     |  |                                     |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>   | 28b. Time of injury<br><b>M</b>  |   |  |   |  |                                     |  |                                     |  |
|  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  |   |  |                                     |  |                                     |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |                                     |  |                                     |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |                                     |  |                                     |  |
| 29b. Signature and title of certifier<br><b>► Jonathan Duran, M.D.</b>   |  | 29c. License number<br><b>D66249</b>  | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>   |   |  |   |  |                                     |  |                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jonathan Duran, MD 1500 Forest Glen Rd, Silver Spring, MD 20910</b>   |  |   |  |   |  |   |  |                                     |  |                                     |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br><b>James A. Galler</b>   |  |   |  |   |  |                                     |  |                                     |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

|  |  |
|--|--|
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial record.   |  |
| 1. Was the decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |
| 2. Was there an injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 3. Describe how injury occurred  |  |
| 4. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 5. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 6. Signature and title of certifier<br><b>► Jonathan Duran, M.D.</b>   |  |
| 7. License number<br><b>D66249</b>   |  |
| 8. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>   |  |
| 9. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jonathan Duran, MD 1500 Forest Glen Rd, Silver Spring, MD 20910</b>  |  |
| 10. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  |
| 11. Registrar's Signature<br><b>James A. Galler</b>  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15280

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial slip.

State  
Registrar

|  |  |   |                          |  |  |
|--|--|---|--------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH MELVIN PROCTOR</b>   |  |   |                          | 2. Date of Death<br>Month Day Year<br><b>July 26, 2012</b>   | 3. Time of Death<br>15:50 P.M.                                     |
| 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |                          | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  |
| 5. Social Security Number<br><b>577-50-5313</b>  |  |   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>78</b><br>Yrs.                |
|  |  |   |                          | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.                                |
|  |  |   |                          | 8. Date of Birth<br>(Month Day Year)<br><b>July 22, 1933</b>   |  |
|  |  |   |                          | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |
| 10a. State<br><b>Maryland</b>  |  |   |                          | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Beltsville</b>                   |
| 10e. Street and Number<br><b>4522 Lincoln Avenue</b>   |  |   |                          | 10f. Zip Code<br><b>20705</b>  |  |
|  |  |   |                          | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Master Electrician</b>   |                          | 16b. Kind of Business/Industry<br><b>Electrical</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Perry Proctor</b>  |  |   |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Louise Linkins</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret D. Proctor -wife</b>   |  |   |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4522 Lincoln Avenue Beltsville, Maryland 20705</b>   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |                          | Date<br><b>4/27/2012</b>   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, PA<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>  |                          |  |  |
| 23a. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                          |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  |   |                          |  |  |
| a. <b>Sepsis</b><br>Due to (or as a consequence of):   |  |   |                          |  |  |
| b. <b>Respiratory Acidosis</b><br>Due to (or as a consequence of):   |  |   |                          |  |  |
| c. <b>Pulmonary Fibrosis</b><br>Due to (or as a consequence of):   |  |   |                          |  |  |
| d. _____   |  |   |                          |  |  |
| Approximate Interval Between Onset and Death   |  |   |                          |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____<br>9 <input type="checkbox"/> Unknown |                          | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                          |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |                          |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                          |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)              |                          | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide |  |
|  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred                                  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of Certifier<br>, MD   |                          |  |  |
|  |  | 29c. License number<br><b>D073240</b>   |                          | 29d. Date signed (Month, Day, Year)<br><b>April 27, 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. Kumar, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910</b>  |  |   |                          |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br>   |                          |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15281

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |  |                                     |
|---|--|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death   |  | 3. Time of Death                    |
| <b>Eloise Pinkney</b>   |  | <b>April 23rd 2012</b>   |  | <b>3:44 a M</b>                     |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death                 |
| <b>Washington Adventist Hospital</b>  |  | <b>Takoma Park</b>   |  | <b>Montgomery</b>                   |
| 5. Social Security Number   |  | 6. Sex   | 7. Age (In yrs. last birthday)   | 8. Date of Birth (Month, Day, Year) |
| <b>579-56-0161</b>  |  | <input type="checkbox"/> M <input checked="" type="checkbox"/> F   | <b>73</b> Yrs.   | <b>03/17/1939</b>                   |
| 9. Birthplace (State or Foreign Country)  |  | 10d. Inside City Limits  |  |                                     |
| <b>Georgia</b>  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                     |
| 10a. State  |  | 10b. County  | 10c. City, Town or Location  |                                     |
| <b>DC</b>   |  | <b>Washington</b>  | <b>Washington</b>  |                                     |
| 10e. Street and Number  |  | 10f. Zip Code  |  | 10g. Citizen of What Country?       |
| <b>436 Oneida Place Northwest</b>   |  | <b>20011</b>   |  | <b>USA</b>                          |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     |
| <input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                 |                                     |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  | 16b. Kind of Business/Industry      |
| <b>Elementary/Secondary (0-12)<br/>12th</b>   |  | <b>Director of Catholic Charities School</b>   |  | <b>Private Industry</b>             |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |                                     |
| <b>Michell Woods</b>  |  | <b>Lillie Mae Wright</b>   |  |                                     |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |                                     |
| <b>David Pinkney /Son</b>   |  | <b>27 Synott Place Newark, New Jersey 07106</b>  |  |                                     |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date   | 20c. Location - City or Town, State |
| <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | <b>Rock Creek Cemetery</b>   | <b>May 01, 2012</b>  | <b>Washington DC</b>                |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility   |  |                                     |
| <b>Tyrone J. Young</b>  |  | <b>5635 Eads Street Northeast<br/>Tyrone J. Young Washington, DC 20019</b>   |  |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |                                     |
| Immediate Cause (Final disease or condition resulting in death)   |  |  |  |                                     |
| 23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |                                     |
| 23c. If yes, outcome of pregnancy   |  |  |  |                                     |
| <input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown  |  |  |  |                                     |
| 23d. Date of delivery   |  |  |  |                                     |
| Month Day Year  |  |  |  |                                     |
| 23e. Did tobacco use contribute to the cause of death?  |  |  |  |                                     |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |                                     |
| 24a. Was an autopsy performed?  |  |  |  |                                     |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |                                     |
| 24b. Were autopsy findings available prior to completion of cause of death?   |  |  |  |                                     |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |                                     |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)  |  |                                     |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                     |
| 27. Manner of Death   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury  | 28c. Injury at work?                |
| <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | M  | <input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
| 29a. Certifier  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                     |
| <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                     |
| 29b. Signature and title of certifier   |  | 29c. License number  |  | 29d. Date signed (Month, Day, Year) |
| <b>S. Martin, MD</b>  |  | <b>D-59284</b>   |  | <b>4/24/2012</b>                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |  |  |                                     |
| <b>S. Martin, MD WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARK</b>   |  |  |  |                                     |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature  |  |                                     |
| <b>MAY 01 2012</b>  |  | <b>MD-20912</b>  |  |                                     |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15282

**1-For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Allan Lewis PURDHAM, II

2. Date of Death

Month Day Year

May 6, 2012

3. Time of Death

1357 hrs

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-02-8682

6. Sex

 M F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (MM/DD/YYYY)

Hours

9. Birthplace (State or Foreign Country)

Min.

Feb. 19, 1971

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

 Yes  No

10e. Street and Number

18323 College Road

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married2  Married

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes2  No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes2  No

Specify:

14. Race - American Indian, Black, White, etc.

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inventory-control

16b. Kind of Business/Industry

creamery

17. Father's Name (First, Middle, Last)

Allan Lewis Purdham

18. Mother's Name (First, Middle, Maiden Surname)

Carol Estelle Clemons

19a. Informant's Name/Relationship (Type, Print)

Kristyn Purdham - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18323 College Road, Hagerstown, Maryland 21740

20a. Method of Disposition

1  Burial2  Cremation3  Removal from State4  Donation5  Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

May 10, 2012

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

*Debbie Purdham*

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Occlusive Thrombus of the right coronary artery complicating Atherosclerotic Cardiovascular Disease**

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED #1 as noted, 23a, 27, per me, g928 6-26-12 sm

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month

Day

Year

25. Was case referred to medical examiner?

1  Yes2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA 4  Nursing Home 5  Residence 6  Other:1  Yes2  No3  Probaoi4  Unknown

23e. Did tobacco use contribute to the cause of death?

1  Yes2  No3  Probaoi4  Unknown

24a. Was an autopsy performed?

1  Yes2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes2  No

27. Manner of Death

1  Natural2  Pending Investigation3  Accident4  Suicide5  Could not be determined6  Determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1  Yes2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Ana Rubio*

Ana Rubio MD.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 7, 2012

31. Date filed (Month, Day, Year)

MAY 14 2012

32. Registrar's Signature

*James J. Parker*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15283

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month<br>May Day<br>05 Year<br>2012   | 3. Time of Death<br>12:58 AM   |   |  |  |  |
| Evelyn Friend Poteet   |  | 4a. Facility Name (if not institution, give street and number)<br>10 West High Street   |  | 4b. City, Town, or Location of Death<br>Hancock   | 4c. County of Death<br>Washington  |  |  |
| 5. Social Security Number<br>218-14-5161<br>Usual Residence of Decedent  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>90 Yrs.  | If Under 1 Year<br>Months<br>Days   | If Under 24 Hrs.<br>Hours<br>Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>12/22/1921   | 9. Birthplace (State or Foreign Country)<br>Maryland             |
| 10a. State<br>MD   |  | 10b. County<br>Washington   |  | 10c. City, Town or Location<br>Hancock  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>10 West High Street  |  |   | 10f. Zip Code<br>21750   |   |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Secretary                        |   |  | 16b. Kind of Business/Industry<br>Public Schools   |  |
| 17. Father's Name (First, Middle, Last)<br>Fred Curfman  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hazel Schriever  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Cynthia L. Lehman/Granddaughter  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3920 Cherylbrooke Drive Mechanicsburg, PA 17050 |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Buck Valley Christian   |  |   | Date<br>05/07/2012   | 20c. Location - City or Town, State<br>Warfordsburg, PA  |  |
| 21. Signature of Funeral Service License<br>  |  |   | 22. Name and Address of Facility<br>141 WEst Main Street<br>Grove Funeral Home, P.A. Hancock, MD 21750-0368                                      |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Breast cancer</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |  |   |  |   |  |  |  |
| Approximate Interval Between Onset and Death   |  |   |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D56048   |  |   | 29d. Date signed (Month, Day, Year)<br>May 7, 2012                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Matthew Hahn, 131 North Pennsylvania Avenue, Hancock, MD 21750   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 2012   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

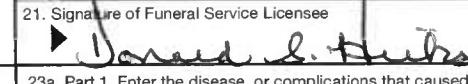
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15284

1 - For  
State  
Registrar

|  |   |  |  |   |   |  |  |   |
|--|---|--|--|---|---|--|--|---|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>John Joseph Paruszewski</b>  |  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>3</b> Year <b>2012</b>                                    | 3. Time of Death<br><b>1558 P.M.</b>                           |  |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>335 Stoney Battery Road</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Earleville</b>   |  | 4c. County of Death<br><b>Cecil</b>              |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>221-10-6711</b>   | 6. Sex<br><b>1 X M 2 □ F</b>   | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT 30, 1925</b>   | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b>    |  |   |
| To Be Completed by Funeral Director                                | 10a. State <b>Maryland</b> 10b. County <b>Cecil</b>   |  |  |   | 10c. City, Town or Location<br><b>Earleville</b>  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b> |   |
|  | 10e. Street and Number<br><b>335 Stoney Battery Road</b>  |  |  |   | 10f. Zip Code<br><b>21919</b>   | 10g. Citizen of What Country?<br><b>United States</b>          |  |   |
|  | 11. Marital Status<br><b>1 □ Never Married 2 □ Married<br/>3 X Widowed 4 □ Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces? <b>World War II</b><br><b>1 X Yes 2 □ No<br/>If Yes, Give Year or Dates.</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b>         |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b> |  |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/Operator</b>                                  |   | 16b. Kind of Business Industry<br><b>Marina</b>   |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Tadeausz Paruszewski</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Glowiaik</b>                            |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John J. Paruszewski, Jr./Son</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>335 Stoney Battery Road, Earleville, MD 21919</b> |   |  |  |   |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co., Inc.</b>  |   | Date<br><b>May 4, 2012</b>  | 20c. Location - City or Town, State<br><b>West Chester, PA</b> |  |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, F.A.<br/>103 W. Stockton Street, Elkton, MD 21921</b>  |   |   |  |  |   |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |   |   |  |  | Approximate Interval Between Onset and Death<br><br><b>CAD (Coronary Artery disease)</b><br><b>CHF (Congestive Heart failure)</b> |
|  | <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |  |   |   |  |  |   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No<br/>9 □ Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (Specify)<br/>9 □ Unknown</b> |   |   |  | 23d. Date of delivery<br>Month Day Year          |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Diabetes</b>   |  |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>                          |
|  | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ D.O.A.</b> Other: <b>4 □ Nursing Home 5 X Residence 6 □ Other (Specify)</b>    |   | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>                              |
|  | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide 4 □ Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>MD</b>   | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>   | 28d. Describe how injury occurred                              |  |   |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>2533 AUGUSTINE HERMAN HWY, SUITE A, CHESAPEAKE CITY, MD 21915</b>         |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>SHAHNAWAZ KHAN</b> |  |  |   |
|  | 29a. Certifier<br>(Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>DOO62190</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/4/12</b>  |  |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHAHNAWAZ KHAN</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 14 2012</b> 32. Registrar's Signature<br><b>Sherman D. Parker</b>  |   |   |  |  |   |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

JOHN PARUSZEWSKI

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1 X /   
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

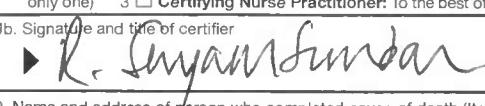
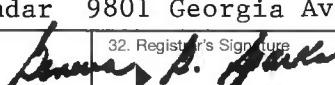
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15285

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |   |   |  |  |
|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Edith May Queen</b>   |   | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>0155 AM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>218-14-2162</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. | If Under 1 Year<br>Months      If Under 24 Hrs.<br>Days      Hours      Min.                   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 29, 1922</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Usual Residence of Decedent  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>12325 New Hampshire Avenue</b>  |   | 10f. Zip Code<br><b>20904</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:   |  | 14. Race - American Indian, Black, White, etc.<br><input type="checkbox"/> Black               |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Companion/Housekeeper</b>  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>James Queen</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Lee</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Harvey - Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3360 Mt. Pleasant Street NW Washington, DC 20010</b>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee's Crematory</b>  | Date<br><b>May 2, 2012</b>                       | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>                                |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc.</b><br><b>4001 Benning Road NE Washington, DC 20019</b>   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   | Approximate Interval Between Onset and Death<br><b>Days</b>   |  |  |
| a. <b>Pneumonia</b><br>Due to (or as a consequence of):  |   |   |  |  |
| b. <b>Dementia</b><br>Due to (or as a consequence of):   |   | <b>Years</b>  |  |  |
| c. Due to (or as a consequence of):  |   |   |  |  |
| d. _____   |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month      Day      Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
|  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D53367</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rajan Shyamsundar</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |  |  |
|  |   | 32. Registrar's Signature<br>  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15286

1- For  
State  
Registrar

|  |  |   |   |   |                                   |   |   |   |  |
|--|--|---|---|---|-----------------------------------|---|---|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>William D. Queen</b>  |   |   |   |                                   | 2. Date of Death<br>Month <b>4</b> Day <b>26</b> Year <b>2012</b> | 3. Time of Death<br>M 26 2012 0530A M   |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Clinton nursing + Rehab</b>   |   |   |   |                                   | 4b. City, Town, or Location of Death<br><b>Clinton, MD</b>        | 4c. County of Death<br><b>PG</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-56-2718</b>  | 6. Sex<br><b>M</b>  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | If Under 1 Year<br>Months<br>Days                               | If Under 24 Hrs.<br>Hours<br>Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>06/17/1953</b>       | 9. Birthplace (State or Foreign Country)<br><b>Cheverly, Md.</b>  |   |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Prince George's</b>   | 10c. City, Town or Location<br><b>Capitol Heights</b>   |   |                                   |   |   |   |  |
|  | 10e. Street and Number<br><b>4147 Southern Ave. # T-4</b>  |   |   | 10f. Zip Code<br><b>20743</b>                                   |                                   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                    |   |   |  |
|  | 11. Marital Status<br><b>X Never Married</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>Yes</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>No</b>                        | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>  |                                   |   |   |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   | 16b. Kind of Business/Industry<br><b>Transportation</b>   |   |                                   |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Queen</b>  |   |   |                                   |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Darnell Nash/Son</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>47 Cable Hollow Way, Largo, Maryland 20774</b>                              |   |   |                                   |   |   |   |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><b>Burial</b>  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cem.</b>  | Date<br><b>05/09/12</b>   | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b> |                                   |   |   |   |  |
| To Be Completed by Physician/Medical Examiner                      | 21. Signature of Funeral Service Licensee<br><b>Dany R. O'Leary CC#0316</b>  | 22. Name and Address of Facility<br><b>Henry S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Washington, D.C. 20019</b>                                       |   |   |                                   |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End stage liver Disease</b>   |   |   |   |                                   |   | Approximate Interval Between Onset and Death  |   |  |
|  | b. Due to (or as a consequence of):<br><b>End stage Renal Disease</b>  |   |   |   |                                   |   |   |   |  |
|  | c. Due to (or as a consequence of):<br><b>End stage HIV</b>  |   |   |   |                                   |   |   |   |  |
|  | d.   |   |   |   |                                   |   |   |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>Yes</b>  | 23c. If yes, outcome of pregnancy<br><b>Live Birth</b> <b>Fetal death</b> <b>Ectopic pregnancy</b><br><b>Pregnant at time of death</b> <b>Other (specify)</b><br><b>Unknown</b> |   |   |                                   |   | 23d. Date of delivery<br>Month   Day   Year   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                                   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>Yes</b> <b>No</b> <b>Probably</b> <b>Unknown</b> |   |  |
|  |  |   |   |   |                                   |   | 24a. Was an autopsy performed?<br><b>Yes</b> <b>No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>Yes</b> <b>No</b> |  |
|  | 25. Was case referred to medical examiner?<br><b>Yes</b> <b>No</b>   | Hospital:   | 26. Place of Death (Check only one)<br><b>Inpatient</b> <b>ER/Outpatient</b> <b>DOA</b> <b>Nursing Home</b> <b>Residence</b> <b>Other (Specify)</b> |   |                                   |   |   |   |  |
|  | 27. Manner of Death<br><b>Natural</b> <b>Pending Investigation</b><br><b>Accident</b> <b>Caused by own acts</b><br><b>Suicide</b> <b>Caused by negligence of others</b><br><b>Homicide</b> <b>Caused by negligence of self</b>   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>Yes</b> <b>No</b>                    | 28d. Describe how injury occurred |   |   |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                   |   |   |   |  |
|  | 29a. Certifier<br>(Check only one)<br><b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |                                   |   | 29c. License number<br><b>R135106</b>   | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>   |  |
|  | 29b. Signature and title of certifier<br><b>Jennifer Frey CRNP</b>   |   |   |   |                                   |   |   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Frey 6934 Anichon Blvd Ste B. Glen Burnie, MD 21061</b>  |   |   |   |                                   |   |   |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  | 32. Registrar's Signature<br><b>J. Davis</b>  |   |   |                                   |   |   |   |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |
|--|--|
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.   |  |
| To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.   |  |
| To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |  |
| State<br>Registrar   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, 29A, PER MD G929 7/17/12 TRT

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15287

1 - For  
State  
Registrar

|  |  |   |   |   |  |   |  |  |
|--|--|---|---|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor F. Reynolds</b>   |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 24, 2012</b>   | 3. Time of Death<br>1719 P M   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>1765 Frenchtown Road</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Port Deposit</b>   |  | 4c. County of Death<br><b>Cecil</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>222-10-0254</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>02/19/1923</b>   | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b>  |  |
|  | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Cecil</b>   |   |   | 10c. City, Town or Location<br><b>Port Deposit</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>1765 Frenchtown Road</b>  |   |   | 10f. Zip Code<br><b>21904</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11</b>   |   | 16. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |   | 16b. Kind of Business Industry<br><b>Own Home</b>                                      |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Theodore Jones</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Glick</b>  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles E. Carter / son</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1765 Frenchtown Road, Port Deposit, MD 21904</b>  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Gracelawn Memorial Park</b>                       |   | Date<br><b>05/01/2012</b>  | 20c. Location - City or Town, State<br><b>New Castle, DE</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Strano &amp; Feeley Family Funeral Home<br/>635 Churchmans Road, Newark DE 19702</b>     |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |   | Approximate Interval Between Onset and Death   |  |
|  | <p>a. Due to (or as a consequence of):<br/><b>right heart Failure</b></p> <p>b. Due to (or as a consequence of):<br/><b>COPD</b></p> <p>c. Due to (or as a consequence of):<br/><b>PE</b></p> <p>d. Due to (or as a consequence of):<br/><b>pulmonary hypertension</b></p>   |   |   |   |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>HTN</b><br><b>PE</b><br><b>Venous insufficiency - edema</b>   |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |   | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  |  |
|  |  |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br><b>210005321</b>   |   |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br>  | 29d. Date signed (Month, Day, Year)<br><b>4-26-12</b>   |   |   |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Susan L. Pelusoma 558 Stanton-Christians Rd, Newark DE 19713</b>  |   |   |   |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>4-27 APR 2012</b>  | 32. Registrar's Signature<br>   |   |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend 75 Per FH G931 9/20/2012 JH  
 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15288

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
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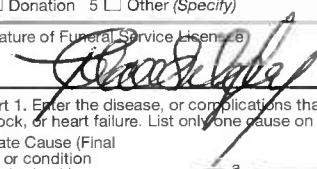
JN-5  
State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>2:10 AM  |
| Ruth Vernie Ridenour   |  | April 30 12  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Fahrney-Keedy Home &amp; Village</b>  |  | 4b. City, Town, or Location of Death<br><b>Boonsboro</b>   |   | 4c. County of Death<br><b>Washington</b>                                       |
| 5. Social Security Number<br><b>2585</b><br><b>217-12-2582</b>   |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs.   | If Under 1 Year<br>Months Days Hours Min.                                      |
| Usual Residence of Decedent<br><b>Maryland</b>   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov 13, 1924</b>  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                    |
| 10c. City, Town or Location<br><b>Boonsboro</b>  |  | 10f. Zip Code<br><b>21713</b>  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                                   |
| 10e. Street and Number<br><b>8507 Mapleville Road</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><b>1 Never Married 2 Married<br/>3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No<br/>If Yes, Give Year or Dates.</b>   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b> | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                 |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Key Punch Operator</b>                  |   | 16b. Kind of Business/Industry<br><b>Federal Government</b>                    |
| 17. Father's Name (First, Middle, Last)<br><b>Harry U. Leatherman</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vernie Catherine Schroyer</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joann R. Franklin/daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1812 Old National Pike Middletown, MD 21769</b>        |   |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State<br/>4 Donation 5 Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery</b>  | Date<br><b>05/05/2012</b>   | 20c. Location - City or Town, State<br><b>Boonsboro, Maryland</b>              |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Bast-Stauffer Funeral Home, PA<br/>7606 Old National Pike Boonsboro, MD 21713</b>                                   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death   |   |  |
| a. Due to (or as a consequence of):<br><b>Pneumonia</b>  |  |  |   |  |
| b. Due to (or as a consequence of):<br><b>Hypoxia</b>  |  |  |   |  |
| c. Due to (or as a consequence of):  |  |  |   |  |
| d. _____   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No<br/>9 Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy<br/>4 Pregnant at time of death 5 Other (specify)<br/>9 Unknown</b> |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Stroke<br/>Atrial Fibrillation</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DDA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>       |   |  |
| 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 Yes 2 No</b><br>28d. Describe how injury occurred |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>D0050362</b>   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-30-12</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vincent Cantore 13424 Pennsylvania Ave Abington PA 19011</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |   |  |
|  |  | 32. Registrar's Signature<br>   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15289

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lena Mae Reid

2. Date of Death

Month Day Year  
April 30, 2012

3. Time of Death

10:25 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

231-22-9609

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 27, 1924

9. Birthplace (State or Foreign Country)

North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State MD

10b. County Washington

10c. City, Town or Location

10e. Street and Number

154 North Artizan Street

10f. Zip Code

21795

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12  
College (1-4 or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bank Teller

16b. Kind of Business Industry

Finance

17. Father's Name (First, Middle, Last)

Luther Nash

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Faris

19a. Informant's Name/Relationship (Type, Print)

Richard M. Reid / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Manassas Drive, Falling Waters, WV 25419

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

5/3/2012 Brentwood, Maryland

21. Signature of Funeral Service Licensee

► Richard M. Reid

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End stage Dementia

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home5  Residence6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending  
2  Accident Investigation  
3  Suicide 6  Could not be determined  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M

1  Yes 2  No

28d. Describe how injury occurred

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Shahid Mahmood MD

29c. License number

S0063233

29d. Date signed (Month, Day, Year)

05/02/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahid Mahmood 580C Northeen Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

MAY 03 2012

32. Registrar's Signature

Shahid Mahmood

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.

To the Physician/Medical Examiner: After this certificate has been signed by the physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15290

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Rison, Regina M/22668

Baltimore, Maryland 21215-0036

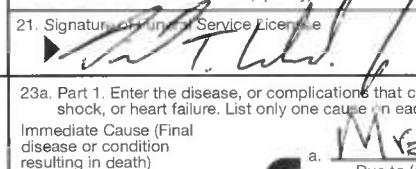
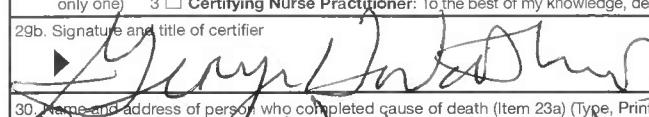
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |             |   |                                |  |                                     |
|--|-------------|---|--------------------------------|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)   |             | 2. Date of Death  |                                | 3. Time of Death   |                                     |
| Regina Loretto Rison   |             | Month   | Day                            | Year   | 4:01 P M                            |
| 4a. Facility Name (if not institution, give street and number)   |             | 4b. City, Town, or Location of Death  |                                | 4c. County of Death  |                                     |
| Civista Medical Center   |             | La Plata  |                                | Charles  |                                     |
| 5. Social Security Number  |             | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.                    |
| 219-56-0401  |             | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 61 Yrs.                        | Months   | Days                                |
| Usual Residence of Decedent  |             |   |                                | Hours  | Min.                                |
| 10a. State   | 10b. County | 10c. City, Town or Location   |                                |  |                                     |
| Maryland   | Charles     | La Plata  |                                |  |                                     |
| 10e. Street and Number   |             | 10f. Zip Code   |                                | 10g. Citizen of What Country?  |                                     |
| 9955 Della Court   |             | 20646   |                                | United States  |                                     |
| 11. Marital Status   |             | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   |                                     |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |             | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                     |
| 15. Decedent's Education (Specify only highest grade completed)  |             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                | 16b. Kind of Business/Industry   |                                     |
| Elementary/Secondary (0-12)  |             | College (1-4 or 5+)   |                                | Account Manager Insurance  |                                     |
| 17. Father's Name (First, Middle, Last)  |             | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |  |                                     |
| John W. Pugh   |             | Mary L. Pugh  |                                |  |                                     |
| 19a. Informant's Name/Relationship (Type, Print)   |             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |                                     |
| John Pugh/Brother  |             | P.O. Box 2383 La Plata, Maryland 20646  |                                |  |                                     |
| 20a. Method of Disposition   |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date   | 20c. Location - City or Town, State |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |             | Sacred Heart Cemetery   |                                | 05-01-2012   | La Plata, Maryland                  |
| 21. Signature on Funeral Service License   |             | 22. Name and Address of Facility  |                                | Arehart-Echols Funeral Home, P.A.  |                                     |
|    |             | M01458  |                                | 211 St. Mary's Ave. La Plata, Maryland 20646   |                                     |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |   |                                |  |                                     |
| Immediate Cause (Final disease or condition resulting in death)  |             |   |                                |  |                                     |
| a. Due to (or as a consequence of):<br><br><br>Myelostatic Cancer of Ovary  |             |   |                                |  |                                     |
| b. Due to (or as a consequence of):  |             |   |                                |  |                                     |
| c. Due to (or as a consequence of):  |             |   |                                |  |                                     |
| d. _____   |             |   |                                |  |                                     |
| Approximate Interval Between Onset and Death   |             |   |                                |  |                                     |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |             | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                                | 23d. Date of delivery<br>Month Day Year  |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |   |                                |  |                                     |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |             |   |                                |  |                                     |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |                                | 23f. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                     |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |             | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
|  |             | M   |                                |  |                                     |
|  |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                     |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             |   |                                |  |                                     |
| 29b. Signature and title of certifier<br>   |             | 29c. License number<br>D20629   |                                | 29d. Date signed (Month, Day, Year)<br>4/26/12   |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>George H. Watson MD, Walpole, Md. 20603  |             |   |                                |  |                                     |
| 31. Date filed (Month, Day, Year)<br>APR 27 2012   |             | 32. Registrar's Signature<br>  |                                |  |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15291

1- For  
State  
Registrar

|  |   |  |  |   |  |   |  |  |
|--|---|--|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Elois D. Russell</b>   |  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>2012</b>   | 3. Time of Death<br><b>3:13 PM</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Southern Maryland Hospital</b>   |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>264-70-0847</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72 Yrs.</b>  | If Under 1 Year<br>Months      Days      Hours      Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>6/26/1939</b>  | 9. Birthplace (State or Foreign Country)<br><b>Florida</b>                                     |  |
|  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>                                      |   | 10c. City, Town or Location<br><b>Upper Marlboro</b>     |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>9809 Muirfield Drive</b>   |  |  | 10f. Zip Code<br><b>20772</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>Black</b> |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                        |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Will Edwards</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes George</b>  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Russell/Daughter</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4913 Marlborough Grove Upper Marlboro, MD 20772</b> |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>   |  | Date<br><b>5/2/2012</b>   | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>                                   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Kenneth Phifer M0549</b>  |  |  | 22. Name and Address of Facility<br><b>Lee Funeral Home Inc.<br/>6633 Old Alexandria Ferry Rd. Clinton, MD 20735</b>                                    |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>breast cancer</b><br>Approximate Interval Between Onset and Death  |  |  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23b. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>breast cancer</b><br>Approximate Interval Between Onset and Death  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hepatitis encephalopathy</b>   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Judith E. S. Sammons</b>  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D69737</b>  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>   |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Judith E. S. Sammons 7503 Surratts Rd. Clinton, MD 20735</b>   |  |  |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |  |  |   |  |   |  |  |
| State Registrar  | 32. Registrar's Signature<br><b>Anna B. Parker</b>  |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

BL-S

## Certificate of Death

Reg. No.

1- For State  
RegistrarPhysician/  
Medical ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

**Division of Vital Records, P.O. Box 68760:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Hospital or Attending Physician:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |   |  |   |
|---|---|--|---|
| 1 Decedent's Name (First, Middle, Last)<br><b>Harvey S. Richardson, Jr.</b>   |   | 2. Date of Death<br>Month Day Year<br><b>April 22, 2012</b>  | 3. Time of Death<br><b>1724 hrs</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>9617 Quiet Brook Lane</b>  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   |
| 4c. County of Death<br><b>Prince George's</b>   |   |  |   |
| 5. Social Security Number<br><b>155 66 7716</b>   | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>50 Yrs.</b>   | 8. Date of Birth (MM/DD/YYYY)<br><b>Dec 12, 1961</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>                           |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>  |   |
| 10c. City, Town or Location<br><b>Clinton</b>   |   | 10f. Zip Code<br><b>20735</b>  |   |
| 10e. Street and Number<br><b>9617 Quiet Brook Lane</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Black</b>   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Law Enforcement</b> | 16b. Kind of Business/Industry<br><b>Pentagon Security Manager</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Harvey S. Richardson, Sr.</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia (unknown)</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Colby Emery Richardson (Wife)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9617 Quiet Brook Lane, Clinton, MD 20735</b>   |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>   | Date<br><b>April 24, 2012</b>   |
| 20c. Location - City or Town, State<br><b>Clinton, MD</b>   |   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Doris L. Grant no257</b>  |   | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>  |   |
| 28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |
| a. Contact Gunshot Wound of Head<br>Due to (or as a consequence of):  |   |  |   |
| b. _____<br>Due to (or as a consequence of):  |   |  |   |
| c. _____<br>Due to (or as a consequence of):  |   |  |   |
| d. _____  |   |  |   |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b> | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |   |  |   |
| 24a. Was an autopsy performed?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   |
| 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene                    |   |
| 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined<br/>4 <input type="checkbox"/> Homicide</b>  |   | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Apr 22, 2012</b>   | 28b. Time of Injury<br><b>FOUND: 1715 hrs</b>   |
|   |   | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   | 28d. Describe how injury occurred<br><b>Subject shot self</b>   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>(Specify) Single Family Home</b>  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>9617 Quiet Brook Lane, Clinton, MD</b> |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |
| 29b. Signature and title of certifier<br><b>Ana Rubio MD.</b>   |   | 29c. License number<br><b>O.C.M.E.</b>   | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>   |   | 32. Registrar's Signature<br><b>Laura S. Parker</b>  |   |

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

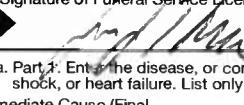
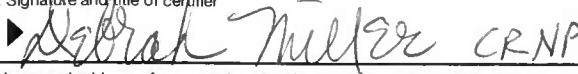
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15293

For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |   |   |  |   |   |  |
|--|--|---|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Inels Agatha Rouse</b>  |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>29</b> , Year <b>2012</b> |  |   | 3. Time of Death<br><b>0545 M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Montgomery Hospice Casey House</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>                |  |   | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>594-52-3380</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>63 Yrs.</b>                        | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | Hours   | Min.   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>MAR 16, 1949</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Jamaica</b>  |   |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |   |   |  |
| 10e. Street and Number<br><b>10 Dalamar Street, #6</b>   |  |   |   | 10f. Zip Code<br><b>20877</b>  |   |   | 10g. Citizen of What Country?<br><b>Jamaica</b>                |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>  |   | 16b. Kind of Business/Industry<br><b>Certified Nursing Assistant</b>   |   |   | 16c. Kind of Business/Industry<br><b>Home Healthcare</b>       |
| 17. Father's Name (First, Middle, Last)<br><b>Lee</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sinclair</b>   |   | 19. Informant's Name/Relationship (Type, Print)<br><b>Donnette Simone Stanley/Daughter</b>  |  |
|  |  |   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12406 Great Park Circle #201 Germantown, MD 20876</b> |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Reshavon MG Crematory</b>  |   | Date<br><b>04/30/2012</b>  | 20c. Location - City or Town, State<br><b>Frederick, MD</b>                                 |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877</b>   |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   |   |  |
| a. <b>CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____   |  |   |   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>                      |   |  |   | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADENOCARCINOMA</b>  |  |   |   |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>  |  |   |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)</b> <b>HOSPICE</b> |   |  |   |   |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Only one. 3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>R143201</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4-29-12</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEBRAH MILLER, CRNP, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855</b>  |  |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |   |   |  |

**Baltimore, Maryland 21215-0036**

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at:

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-vansit.

**To Be Completed by Funeral Director**

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15294

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>12:58 P M  |
| Victoria Joan Slodyczka  |  | April 28 2012  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><br>5842 Brooks Woods Road   |  | 4b. City, Town, or Location of Death<br><br>Lothian  |   | 4c. County of Death<br><br>Anne Arundel  |
| 5. Social Security Number<br><br>147-10-4313   |  | 6. Sex<br><br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><br>91 Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br>10-17-1920  |
| Usual Residence of Decedent<br><br>MD  |  | 10a. State<br><br>Anne Arundel   |   | 10d. Inside City Limits<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10b. County<br><br>Anne Arundel  |  | 10c. City, Town or Location<br><br>Lothian   |   | 10g. Citizen of What Country?<br><br>USA   |
| 10e. Street and Number<br><br>5842 Brooks Woods Road   |  | 10f. Zip Code<br><br>20711   |   |  |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:    |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br>College (1-4 or 5+) Florist shop proprietor  |   | 14. Race - American Indian, Black, White, etc.<br><br>Specify: White   |
| 17. Father's Name (First, Middle, Last)<br><br>Joseph Nawalaniec   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><br>Antonia Sclonkwiecz   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><br>Vikki A. Etchison, Granddaughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br>5842 Brooks Woods Road, Lothian, MD 20711   |   |  |
| 20a. Method of Disposition<br><br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>► William B. Etchison M00715  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br>Metropolitan Crematory 04-30-12  |   | 20c. Location - City or Town, State<br><br>Alexandria, VA  |
| 21. Signature of Funeral Service Licensee<br><br>► William B. Etchison M00715  |  | 22. Name and Address of Facility<br><br>Rausch Funeral Home, P.A.<br>8325 Mt. Harmony Lane, Owings, MD 20736   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part 2. Enter the disease, or complications that contributed to the death but did not result in the underlying cause given in Part I.   |   | Approximate Interval Between Onset and Death<br><br>1 day<br>3 yrs   |
| <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p>   |  | <p>a. Due to (or as a consequence of):<br/><br/>Aspiration</p> <p>b. Due to (or as a consequence of):<br/><br/>Cerebral Vascular Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                      | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Describe how injury occurred<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>A45235  |   | 29d. Date signed (Month, Day, Year)<br>4/30/2018   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Catherine Brophy, M.D., Dunkirk, MD 20754  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 2012   |  | 32. Registrar's Signature<br>Catharine S. Brophy   |   |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15295

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>0618 hrs |
| <b>Juan Diaz Salmeron</b>                | May 5, 2012                        |                              |

**Funeral Director**

|  |  |   |
|--|--|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>Frederick Memorial Hospital</b> | 4b. City, Town, or Location of Death<br><b>Frederick</b> | 4c. County of Death<br><b>Frederick</b> |
|--|--|---|

**To Be Completed by Funeral Director**

|  |   |   |   |
|--|---|---|---|
| 5. Social Security Number<br><b>none</b> | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>44</b> | If Under 1 Year<br>Months Days Hours Min. |
|--|---|---|---|

5/16/1967

El Salvador

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Baltimore, MD 21215-0036****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

Immediate Cause (Final disease or condition resulting in death) **a. Hypertensive Atherosclerotic Cardiovascular Disease**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

UNPENDED  AMENDED **23a,27,per me,g944 10-23-13 sm**

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA 4  Nursing Home 5  Residence 6  Other: Scene

27. Manner of Death  
1  Natural 5  Pending Investigation  
2  Accident  
3  Suicide 6  Could not be determined  
4  Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number  
**O.C.M.E.**

29d. Date signed (Month, Day, Year)  
**May 6, 2012**

30. Name and address of person who completed cause of death (Item 23a)  
**Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223**

31. Date filed (Month, Day, Year)  
**MAY 09 2012**

32. Registrar's Signature  
*James J. Park*

**ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15296

1 - For  
State  
Registrar

|  |  |                          |   |                           |  |  |  |  |
|--|--|--------------------------|---|---------------------------|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Christine Smith</b>  |                          |   |                           |  | 2. Date of Death<br>Month <b>May</b> Day <b>2</b> Year <b>2012</b>                               | 3. Time of Death<br><b>0527 AM</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>  |                          |   |                           |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-58-9415</b>  | 6. Sex<br><b>1 M 2 F</b> | 7. Age (In yrs. last birthday)<br><b>58 Yrs.</b>  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>06/05/1953</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Hagerstown, MD</b>                                |  |
|  | 10a. State <b>MD</b> 10b. County <b>Washington</b> 10c. City, Town or Location <b>Hagerstown</b>   |                          |   |                           |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>32 Church Street</b>  |                          |   |                           |  | 10f. Zip Code<br><b>21740</b>  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates.   |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b> Specify: |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>                                   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10 th</b>   |                          | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Homemaker</b>  |                           | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ralph Nathaniel Beckett</b>  |                          |   |                           |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cynthia Hankins</b>                      |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruki K. Medley / Son</b>  |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>204 Brookside Terrace, Hagerstown, MD 21742</b>   |                           |  |  |  |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematorium</b>   |                           | Date<br><b>05/04/2012</b>  | 20c. Location - City or Town, State<br><b>Smithsburg, MD</b>                                     |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |                          | 22. Name and Address of Facility<br><b>Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740</b>  |                           |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                          |   |                           |  | Approximate Interval Between Onset and Death   |  |  |
|  | <p>a. Due to (or as a consequence of):<br/><b>Sepsis shock</b></p> <p>b. Due to (or as a consequence of):<br/><b>Diabetes mellitus</b></p> <p>c. Due to (or as a consequence of):<br/><b>Urinary retention</b></p> <p>d. _____</p>   |                          |   |                           |  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b>   |                          | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>  |                           | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                          |   |                           |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |  |
|  |  |                          |   |                           |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |
|  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |                          | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DDA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>  |                           |  |  |  |  |
|  | 27. Manner of Death<br><b>1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>  |                          | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 Yes 2 No</b>  | 28d. Describe how injury occurred  |  |  |
|  |  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician 2 Medical Examiner 3 Certifying Nurse Practitioner</b>   |                          | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                           |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |                          | 29c. License number<br><b>D0070027</b>  |                           | 29d. Date signed (Month, Day, Year)<br><b>5/31/2012</b>                                |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hazia Amsler 11116 Medical campus Road Hagerstown</b>   |                          |   |                           |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 09 2012</b>  |                          | 32. Registrar's Signature<br>  |                           |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2012 15291

|  |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
|--|--|---|---|---|---|---|--|--|---|--|--|--|--|--|--|
| For<br>State<br>Registrar  |  | State of Maryland / Department of Health and Mental Hygiene   |   | Certificate of Death  |   | Reg. No.  | 2012   | 15297  |   |  |  |  |  |  |  |
| 1. Decedent's Name (First, Middle, Last)   |  |   |   |   |   | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death<br>2:45 AM  |   |  |  |  |  |  |  |
| Patricia Ann Smith   |  |   |   |   |   | April 27 2012   |  |  |   |  |  |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  |   | 4b. City, Town, or Location of Death  |   |   | 4c. County of Death   |  |  |   |  |  |  |  |  |  |
| 2135 Haleys Way  |  |   | Owings  |   |   | Calvert   |  |  |   |  |  |  |  |  |  |
| 5. Social Security Number<br>219-42-3052   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.   |   | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>08-15-1944  |  | 9. Birthplace (State or Foreign Country)<br>Wash., D.C.  |   |  |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Calvert  |   | 10c. City, Town or Location<br>Owings   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |  |  |  |
| 10e. Street and Number<br>2135 Haleys Way  |  |   |   | 10f. Zip Code<br>20736  |   |   | 10g. Citizen of What Country?<br>USA                             |  |   |  |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |  |  |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   |   | 16b. Kind of Business/Industry<br>Own Home                       |  |   |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>James Thomas Ellis  |  |   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Betty Ann Anderson                                   |  |  |   |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Raymond S. Smith, Sr., Spouse  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2135 Haleys Way, Owings, MD 20736  |   |   |   |  |  |   |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>M00715  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery  |   |   | Date<br>05-01-2012  | 20c. Location - City or Town, State<br>Brentwood, MD             |  |   |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>► William R. Grier  |  |   | 22. Name and Address of Facility<br>Rausch Funeral Home, P.A.<br>8325 Mt. Harmony Lane, Owings, MD 20736  |   |   |   |  |  |   |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>CHOLEDOCHAL CARCINOMA<br>24. Approximate Interval Between Onset and Death<br>2412  |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. _____  |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 25. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |   | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      | 28d. Describe how injury occurred                                |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number<br>D29657   |   |   | 29d. Date signed (Month, Day, Year)<br>4/27/2012  |  |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>► Charles Judge, MD   |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Charles Judge, MD, 110 Hospital Road, Prince Frederick, MD 20678   |  |   |   |   |   |   |  |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 27 2012   |  |   | 32. Registrar's Signature<br>Lorraine J. Patel  |   |   |   |  |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

**To The Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15298

|   |  |  |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
|---|--|--|--|--|---|--|---|--|--|---|---|---|---|--|--|--|--|
| Physician/<br>Medical Examiner                |  | 1. Decedent's Name (First, Middle, Last)<br><b>Dennis Kevin Scott</b>  |  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 23, 2012</b>   |  |  | 3. Time of Death<br>1750 hrs  |   |   |   |  |  |  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>703 Oxbow Lane</b>  |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lusby</b>  |  |  | 4c. County of Death<br><b>Calvert</b>                                   |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>220-56-3123</b>  |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>61 Yrs.</b>  | If Under 1 Year<br>Months<br><b>04</b>   | If Under 24 Hrs.<br>Days<br><b>23</b>   | Hours<br><b>00</b>   | Min.<br><b>00</b>  | 8. Date of Birth (MM/DD/YYYY)<br><b>04/23/1951</b>                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |   |  |  |  |  |
| To Be Completed by Funeral Director           |  | 10a. State<br><b>Maryland</b>  |  |  |   |  | 10b. County<br><b>Calvert</b>   |  |  |   |   | 10c. City, Town or Location<br><b>Lusby</b>   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>703 Ox Bow Lane</b>   |  |  |   |  | 10f. Zip Code<br><b>20657</b>   |  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |   |   |   |  |  |  |  |
| Physician/<br>Medical Examiner                |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Communications Specialist</b>   |  |  |   |   | 16b. Kind of Business/Industry<br><b>Government Contractor</b>  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Raymond Francis Scott</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sheila Catherine Ferris</b>   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joanne Sykes / Sister</b>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>623 Tayman Drive, Annapolis, MD 21403</b>   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b> |  |   | Date<br><b>04/26/2012</b>  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b><i>Sherry Scott</i></b>  |  |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>P.O. Box 600, Lusby, MD 20657</b>  |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |   |  |  |   |   | Approximate Interval Between Onset and Death  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | a. <u>Shotgun Wound to head</u><br>Due to (or as a consequence of):  |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | b. _____<br>Due to (or as a consequence of):   |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | c. _____<br>Due to (or as a consequence of):   |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | d. _____   |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | <input type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED   |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b> |   |  |   |  | 23d. Date of delivery<br>Month Day Year  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  |  |  |  |   |  |   |  |  |   |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |   |  |   |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of Injury<br><b>Apr 23, 2012</b>   |   | 28b. Time of Injury<br><b>0000 hrs</b>   |   | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  | 28d. Describe how injury occurred<br><b>Subject shot self</b>           |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>(Specify) residence</b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>703 Oxbow Lane, Lusby, MD</b> |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 29b. Signature and title of certifier<br><b><i>Zabiullah Ali, M.D.</i></b>   |  |  |   |  | 29c. License number<br><b>O.C.M.E.</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 24, 2012</b>            |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |  |   |  |   |  |  |   |   |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br><b><i>Dennis J. Scott</i></b>   |   |  |   |  |  |   |   |   |   |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15299

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |                               |  |  |   |  |  |      |
|---|-------------------------------|--|--|---|--|--|------|
| 1. Decedent's Name (First, Middle, Last)  |                               | 2. Date of Death   |  |   |  | 3. Time of Death   |      |
| <b>Doris Delaine Snyder</b>   |                               | Month 04   |  | Day 28  |  | Year 2012  |      |
| 4a. Facility Name (if not institution, give street and number)  |                               | 4b. City, Town, or Location of Death   |  |   |  | 4c. County of Death  |      |
| Garrett Memorial Hospital   |                               | Oakland  |  |   |  | Garrett  |      |
| 5. Social Security Number<br><b>216-34-2783</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days                                   | Hours  | Min. |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>11/09/1936</b>   |                               | 9. Birthplace (State or Foreign Country)<br><b>WV</b>  |  |   |  |  |      |
| 10a. State<br><b>WV</b>   | 10b. County<br><b>Preston</b> | 10c. City, Town or Location<br><b>Aurora</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |      |
| 10e. Street and Number<br><b>296 Cooper Lane</b>  |                               | 10f. Zip Code<br><b>26705</b>  |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |      |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |                               | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)                    |  | 16b. Kind of Business/Industry<br><b>Homemaking</b>   |  |  |      |
| 17. Father's Name (First, Middle, Last)<br><b>John McDaniel</b>   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josie Lipscomb</b>   |  |   |  |  |      |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ellen Elmo / Sister</b>  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22080 George Washington Hwy., Aurora, WV 26705</b> |  |   |  |  |      |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Gardens Crematory</b>                                     |  | Date<br><b>4/30/2012</b>  | 20c. Location - City or Town, State<br><b>Kingwood, WV</b> |  |      |
| 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>Burdock-Fredlock Funeral Home, P.O. Box 21 North Second Street, Oakland, MD 21550</b>                           |  |   |  |  |      |

Physician/  
Medical  
Examiner

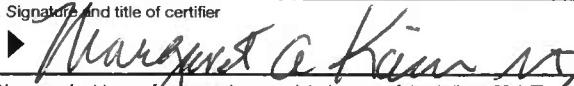
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |   |                          |  |                                   |  |
|--|--|---|--------------------------|--|-----------------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>2 days</b>   |                          |  |                                   |  |
| <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p>   |  | a. Due to (or as a consequence of):<br><b>Urinary sepsis</b>  |                          |  |                                   |  |
|  |  | b. Due to (or as a consequence of):   |                          |  |                                   |  |
|  |  | c. Due to (or as a consequence of):   |                          |  |                                   |  |
|  |  | d. Due to (or as a consequence of):   |                          |  |                                   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____                               |                          |  |                                   |  |
|  |  | 23d. Date of delivery<br>Month Day Year   |                          |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes type, old CVA, hypertension</b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                          |  |                                   |  |
|  |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                          |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          |  |                                   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                          |  |                                   |  |

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  


29c. License number

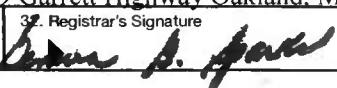
29d. Date signed (Month, Day, Year)

**D26650****4-30-12**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser, MD 13079 Garrett Highway Oakland, MD 21550

31. Date filed (Month, Day, Year)

**APR 30 2012**32. Registrar's Signature  


## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15300

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner****Funeral  
Director****To Be Completed by Funeral Director****Medical Certificate: To Be Completed by Physician/Medical Examiner****Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |   |  |   |  |  |
|--|--|---|---|---|--|---|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Agnes Sears</b>  |   | 2. Date of Death<br>Month Day Year<br><b>April 30, 2012</b>   |  | 3. Time of Death<br>12:45 A M   |  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>WMHS Frostburg Nursing &amp; Rehab Center</b>  |   | 4b. City, Town, or Location of Death<br><b>Frostburg</b>  |  | 4c. County of Death<br><b>Allegany</b>                                  |  |  |
| 5. Social Security Number<br><b>212-24-1705</b>  |  | 6. Sex<br><b>M</b>  | 7. Age (in yrs. last birthday)<br><b>84</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct. 8 1927</b>            | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>  | 10c. City, Town or Location<br><b>Frostburg</b>     |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>14315 New Georges Creek Road</b>  |  |   |   | 10f. Zip Code<br><b>21532</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Case Manager</b>   |   | 16b. Kind of Business/Industry<br><b>Social Security</b>  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Miller</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katie Preston</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Randolph Griffith/ son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO Box 218, Barton, Maryland 21521</b>  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Laurel Hill Cemetery</b>   |   | Date<br><b>05/02/2012</b>   | 20c. Location - City or Town, State<br><b>Barton, Maryland</b>                       |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>► F. Wayne Bal</b>   |  | 22. Name and Address of Facility<br><b>Boal Funeral Home<br/>111 Church St, Westernport, Maryland 21562</b>   |   |   |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><b>Cholangio Carcinoma</b>   |   |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 months</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |   |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |   |   |  |   |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>► Wonock Shin MD</b>   |  | 29c. License number<br><b>00155325</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Wonock Shin, 925 Bishop Walsh Road, Cumberland, MD 21502</b>  |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br><b>Leanne S. Parker</b>  |   |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2012 15301

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month <b>May</b> Day <b>2</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>1304 PM</b>  |
| <b>James Edward Spiker</b>   |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>209 Wood Street</b>   |  | 4b. City, Town, or Location of Death<br><b>Westernport</b>  |  | 4c. County of Death<br><b>Allegany</b>  |
| 5. Social Security Number<br><b>217-54-6921</b>  |  | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs. | If Under 1 Year<br>Months      Days      Hours      Min.  |
| Usual Residence of Decedent<br><b>Maryland Allegany</b>  |  | 10c. City, Town or Location<br><b>Westernport</b>   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 19, 1950</b>   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Allegany</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
| 10e. Street and Number<br><b>209 Wood Street</b>   |  | 10f. Zip Code<br><b>21562</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Loader Operator</b>  |  | 16b. Kind of Business/Industry<br><b>Engineering</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Harrison Spiker</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Smiley</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dinah Spiker/wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>209 Wood Street, Westernport, MD, 21562</b>   |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b>  |  | Date<br><b>May 5, 2012</b>  |
| 21. Signature of Funeral Service Licensee<br><b>J. Wayne Boal</b>  |  | 22. Name and Address of Facility<br><b>Boal Funeral Home P.A., 111 Church St., Westernport, MD</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>Metastatic carcinoma of lung</b><br>Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death<br><b>14yrs</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. _____<br>Due to (or as a consequence of):  | c. _____<br>Due to (or as a consequence of):     | d. _____  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)        |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28d. Describe how injury occurred                |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>16193</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/3/12</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mahesh Shroft 390 Causickardon Lane, Keyser, WV 26726</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY - 3 2012</b>  |  | 32. Registrar's Signature<br><b>Suzanne A. Parker</b>   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15302

1 - For  
State  
Registrar

|  |  |   |   |  |   |  |  |  |  |  |  |
|--|--|---|---|--|---|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Josselyn Alexandra Sanchez</b>                |   |   |  |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> , Year <b>2012</b>                          | 3. Time of Death<br>6:25P. M   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>                 |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>none  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs.<br>Usual Residence of Decedent        | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 24, 2012</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                      |  |  |  |
|  |  |   |   |  | 6   | 43   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| To Be Completed by Funeral Director  | 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b>                                |   |   | 10c. City, Town or Location <b>Hyattsville</b>                               |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
|  | 10e. Street and Number<br><b>3207 Toledo Place, #204</b>                                     |   |   | 10f. Zip Code<br><b>20782</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify<br><b>El Salvadoran</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                       |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0) 12  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>none                                  |  |   | 16b. Kind of Business/Industry<br>none   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joel Sanchez</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carolina Martinez Urias</b>   |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joel Sanchez -father</b>  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3207 Toledo Place, #204 Hyattsville, Maryland 20782</b> |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cem.</b>   |  |   | Date<br><b>4/30/2012</b>   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>                                  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, PA<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>                  |  |   |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |  |
| <p>a. <b>Cardiogenic Shock</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Extreme Prematurity</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Placental Abruption</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |  |   |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  |   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |  |  |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |  |  |  |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 0066134</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/12</b>   |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chrysanthe Gaitatzes, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910</b>  |  |   |   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br>   |   |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|                     |  |
|---------------------|--|
| State Registrar     |  |
| DHMH 17 Rev 06-2011 |  |

ORIGINAL

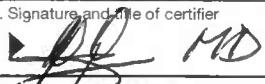
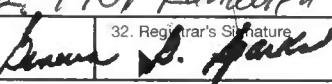
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15303

|  |  |  |   |  |  |   |   |  |
|--|--|--|---|--|--|---|---|--|
| 1 - For State Registrar  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Samuel Sullivan</b>   |   |  |  | 2. Date of Death<br>Month 04 Day 23 Year 2012   | 3. Time of Death<br>9:20 P M  |  |
| Physician/ Medical Examiner  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Washington Adventist Hospital</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral Director   |  | 5. Social Security Number<br><b>259-56-3572</b>  | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>71 Yrs.</b>   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>06/20/1940</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b> |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Prince George's</b>   | 10c. City, Town or Location<br><b>Suitland</b>   | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>   |   |   |  |
|  |  | 10e. Street and Number<br><b>2329 Houston Street</b>   | 10f. Zip Code<br><b>20746</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
|  |  | 11. Marital Status<br>1 □ Never Married 2 X Married<br>3 □ Widowed 4 □ Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 □ Yes 2 X No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                          |   |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                           | 16b. Kind of Business/Industry<br><b>Private</b>   |  |   |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Johnnie Sullivan</b>   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Viola Collier</b>   |  |  |   |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Sullivan/Wife</b>   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2329 Houston Street Suitland, MD 20746</b>                |  |  |   |   |  |
|  |  | 20a. Method of Disposition<br>1 □ Burial 2 X Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   | Date<br><b>4/25/2012</b>   | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                                     |   |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>► ANNA FREDERICK</b>   | 22. Name and Address of Facility<br><b>Marshall-March Funeral Home<br/>4308 Suitland Road Suitland, MD 20746</b>  |  |  |   |   |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | <i>Acute Myocardial Infarct</i><br><i>Coronary Artery Disease</i><br><i>Atherosclerosis</i><br><i>Hypertension</i>  |  |  | Approximate Interval Between Onset and Death  |   |  |
|  |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |   |  |  |   |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown | 23d. Date of delivery<br>Month Day Year  |  |   |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><i>Sepsis</i><br><i>Encephalopathy</i><br><i>Intestinal Ischemia</i>   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown |   |  |
|  |  |  |   |  |  | 24a. Was an autopsy performed?<br>1 □ Yes 2 X No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 X No |  |
|  |  | 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   | Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA   |  | 26. Place of Death (Check only one)<br>Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) |   |   |  |
|  |  | 27. Manner of Death<br>1 □ Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 □ Yes 2 □ No   | 28d. Describe how injury occurred   |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                      |   |  |
|  |  | 29a. Certifier<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |   |  |
|  |  | 29b. Signature and title of certifier<br> MD  | 29c. License number<br><b>47867</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/12</b>   |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ortay Linares 4701 Randolph Rd #216 Rockville, MD 20852</b>   |   |  |  |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  | 32. Registrar's Signature<br>  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15304

1 - For  
State  
Registrar

|  |   |  |  |   |   |   |   |   |  |
|--|---|--|--|---|---|---|---|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)  |  |  |   |   | 2. Date of Death<br>Month April Day 28 Year 2012  | 3. Time of Death<br>9:10 PM   |   |  |
|  | Mary Caroline Taylor  |  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Calvert County Nursing Center</b>  |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |   | 4c. County of Death<br><b>Calvert</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>160-05-1418</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>96</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>07-26-1915</b>   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Calvert</b>  |   | 10c. City, Town or Location<br><b>Dunkirk</b>   |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>11950 Prince Court</b>   |  |  | 10f. Zip Code<br><b>20754</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Silkscreener</b>   |   |   | 16b. Kind of Business/Industry<br><b>Drug Company Advert.</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward A. Kelly</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Caroline Clark</b>  |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leonard Gordon, Jr., Nephew</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11950 Prince Court, Dunkirk, MD 20754</b> |   |   |   |  |
|  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>So. Memorial Gardens</b>   |   | Date<br><b>05-03-2012</b>   | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>William R. Goss</b>   |  |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.</b><br><b>8325 Mt. Harmony Lane, Owings, MD 20736</b>  |   |   |   |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>PARKINSON'S DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of),<br><br>c. Due to (or as a consequence of),<br><br>d. Due to (or as a consequence of),<br><br>Approximate Interval Between Onset and Death   |  |  |   |   |   |   |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>              |   |   | 23d. Date of delivery<br>Month Day Year   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SPINAL STENOSIS, HYPOTHYROIDISM</b>  |  |  |   |   |   |   |   |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>   |  |  |   |   |   |   |   |  |
|  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |   |   |   |   |   |  |
|  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   |   |   |   |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>                                     |   | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   | 28d. Describe how injury occurred   |   |  |
|  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>DS0233</b>   |   |   |   |   |   |  |
|  | 29b. Signature and title of certifier<br><b>Glynis A. Moody, MD</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/30/2012</b>                                |   |   |   |   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GLYNIS A. MOODY, MD 110 HOSPITAL DR, #310 PRINCE FREDERICK, MD 20678</b>   |  |  |   |   |   |   |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne A. Parker</b>                                   |   |   |   |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DRV 10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15305

Reg. No.

1-  
For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Hattie Mae Tolliver</b>   |  | 2. Date of Death<br>Month <b>April</b> Day <b>27</b> , Year <b>2012</b>   |   |  |  | 3. Time of Death<br><b>10:00 am</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>14335 Georgia Avenue, Apt. T1</b>   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>228-40-4818</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>81</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                                      | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 26, 1931</b>  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>                      |
| Usual Residence of Decedent<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Montgomery</b>            | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   |  |
| 10e. Street and Number<br><b>14335 Georgia Avenue, Apt. T1</b>   |  |   |   | 10f. Zip Code<br><b>20906</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>                                |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b>Black</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Supervisor</b>   |   | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Moton</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Etta Griggs</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lynetta Joanne Tolliver/Daughter</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14335 Georgia Avenue, T1, Silver Spring, MD 20906</b>  |  |   |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harrisonburg Cremation Service</b>   |   | Date<br><b>May 5, 2012</b>   | 20c. Location - City or Town, State<br><b>Harrisonburg, VA</b> |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home Inc.<br/>500 University Blvd. W., Silver Spring, MD 20901</b>  |   |  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death  |   |  |  |   |  |
| a. <b>MULTIPLE MYELOMA</b><br>Due to (or as a consequence of):   |  |   |   |  |  |   |  |
| b. <b>CHRONIC KIDNEY DISEASE</b><br>Due to (or as a consequence of):   |  |   |   |  |  |   |  |
| c. _____<br>d. _____   |  |   |   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>      |   |  |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>   |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury                         | 28c. Injury at work?<br><b>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred                              |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D35635</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 27, 2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Kaplan, MD 18111 Prince Philip Drive, Olney, MD 20832</b>  |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br>   |   |  |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15306

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                   |  |  |                |   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|-----------------------------------|--|--|----------------|---|--------------------------------------|--|------------------|---|---|--|---|--|--|---|--|--|
|                                   |  | 1. Decedent's Name (First, Middle, Last)   |                |   |                                      |  |                  |   | 2. Date of Death                                  |  | 3. Time of Death  |  |  |   |  |  |
|                                   |  | <b>William Roger Willett</b>   |                |   |                                      |  |                  |   | Month <u>April</u> Day <u>29</u> Year <u>2012</u> |  | Reg. No. <u>1:20 P M</u>  |  |  |   |  |  |
|                                   |  | 4a. Facility Name (if not institution, give street and number)   |                |   | 4b. City, Town, or Location of Death |  |                  |   | 4c. County of Death                               |  |   |  |  |   |  |  |
|                                   |  | <b>CIVISTA MEDICAL CENTER</b>  |                |   | <b>LAPLATA</b>                       |  |                  |   | <b>CHARLES</b>                                    |  |   |  |  |   |  |  |
| Funeral<br>Director               |  | 5. Social Security Number  |                | 6. Sex  | 7. Age (In yrs. last birthday)       | If Under 1 Year  | If Under 24 Hrs. | 8. Date of Birth  | 9. Birthplace (State or Foreign Country)          |  |   |  |  |   |  |  |
|                                   |  | <b>215-38-6616</b>   |                | <input checked="" type="checkbox"/> M <input type="checkbox"/> F  | <b>76</b> Yrs.                       | Months   | Days             | (Month, Day, Year)  | <b>Maryland</b>                                   |  |   |  |  |   |  |  |
|                                   |  | Usual Residence of Decedent  |                |   |                                      |  |                  | 10d. Inside City Limits   |   |  |   |  |  |   |  |  |
|                                   |  | 10a. State   | 10b. County    | 10c. City, Town or Location   |                                      |  |                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                         |   |  |   |  |  |   |  |  |
|                                   |  | <b>Maryland</b>  | <b>Charles</b> | <b>Nanjemoy</b>   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 10e. Street and Number   |                |   |                                      | 10f. Zip Code  |                  |   | 10g. Citizen of What Country?                     |  |   |  |  |   |  |  |
|                                   |  | <b>8310 Jacksontown Road</b>   |                |   |                                      | <b>20662</b>   |                  |   | <b>U.S.A.</b>                                     |  |   |  |  |   |  |  |
|                                   |  | 11. Marital Status   |                | 12. Was Decedent Ever in U.S. Armed Forces?   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                  |   | 14. Race - American Indian, Black, White, etc.    |  |   |  |  |   |  |  |
|                                   |  | <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |                | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1958-1960</b>   |                                      | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:                              |                  |   | <input type="checkbox"/> White                    |  |   |  |  |   |  |  |
|                                   |  | 15. Decedent's Education (Specify only highest grade completed)  |                |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)    |                  |   | 16b. Kind of Business/Industry                    |  |   |  |  |   |  |  |
|                                   |  | <b>Elementary/Secondary (0-12) 9</b>   |                |   |                                      | <b>Heavy Equipment Operator</b>  |                  |   | <b>County Government</b>                          |  |   |  |  |   |  |  |
|                                   |  | 17. Father's Name (First, Middle, Last)  |                |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | <b>Luke Willett</b>  |                |   |                                      | <b>Katie Maddox</b>  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 19a. Informant's Name/Relationship (Type, Print)   |                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | <b>Katie W. Stickel Daughter</b>   |                | <b>3815 Chinquapin Rd., Nanjemoy, Md. 20662</b>   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 20a. Method of Disposition   |                | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                      | Date   |                  |   | 20c. Location - City or Town, State               |  |   |  |  |   |  |  |
|                                   |  | <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                | <b>Maryland Veterans Cemetery</b>   |                                      | <b>May 4, 2012</b>   |                  |   | <b>Cheltenham, Maryland</b>                       |  |   |  |  |   |  |  |
|                                   |  | 21. Signature of Funeral Service Licensee  |                | 22. Name and Address of Facility  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | <b>Wally Williams</b>  |                | <b>Williams Funeral Home, P.A.</b><br><b>M00668 4270 Hawthorne Rd., Indian Head, Md. 20640</b>  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                | Approximate Interval Between Onset and Death  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | { a. <b>TERMINAL METASTATIC SMALL CELL CANCER OF LUNG</b><br>Due to (or as a consequence of):<br><b>ACUTE RENAL FAILURE</b>  |                | <b>UNKNOWN</b>  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | b. <b>PANCYTOPENIA</b><br>Due to (or as a consequence of):   |                | <b>UNKNOWN</b>  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | c. Due to (or as a consequence of):  |                | <b>UNKNOWN</b>  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | d. _____   |                |   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown   |                                      |  |                  |   |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |  |
|                                   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  |  |                |   |                                      |  |                  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|                                   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |                | 28a. Date of injury (Month, Day, Year)  |                                      | 28b. Time of injury  | M                | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred                 |  |   |  |  |   |  |  |
|                                   |  |  |                |   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 29a. Certifier (Check Only One)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                      |  |                  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |  |   |  |  |
|                                   |  | 29b. Signature and title of certifier<br><b>Samuel J. Kleinman MD</b>  |                | 29c. License number<br><b>D-0026262</b>   |                                      |  |                  |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>4/29/2012</b>   |  |  |   |  |  |
|                                   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |                |   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | <b>Samuel J. Kleinman, MD 11711 Livingstone Rd. Ft. Washington, Md 20744</b>   |                |   |                                      |  |                  |   |   |  |   |  |  |   |  |  |
|                                   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |                | 32. Registrar's Signature<br><b>Samuel J. Kleinman</b>  |                                      |  |                  |   |   |  |   |  |  |   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
 amend item 23 pt. II per doc g928 6-27-12 vt  
 State of Maryland Department of Health and Mental Hygiene

**Physician/  
Medical  
Examiner**

1 - For  
State  
Registrar

**Funeral  
Director**

To Be Completed by Funeral Director  
  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician/  
Medical  
Examiner**

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

**State  
Registrar**

**Certificate of Death**

Reg. No.

2012 15307

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death<br>0940 M   |
| <i>BERNARD ALBERT WALLACE, SR</i>  |  | 04 26 12   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Tate Hospice House</b>  |  | 4b. City, Town, or Location of Death<br><b>Linthicum</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                                   |
| 5. Social Security Number<br><b>216-22-3378</b>  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>85 Yrs.</b>   | If Under 1 Year<br>Months Days Hours Min.                                | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec 30 1926</b>                 |
| Usual Residence of Decedent<br><b>Maryland Anne Arundel</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>                             |
| 10e. Street and Number<br><b>210 Admiral Dr.</b>   |  | 10f. Zip Code<br><b>21401</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |
| 11. Marital Status<br>1 □ Never Married 2 □ Married<br><b>3 X Widowed</b> 4 □ Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 □ Yes 2 X No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X No<br>Specify:                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>0</b>                         | 16b. Kind of Business/Industry<br><b>United States Naval Academy</b>     |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Wallace</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Johns</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Wallace (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 Admiral Dr. Annapolis, Md. 21401</b>                         |  |  |
| 20a. Method of Disposition<br>1 X Burial 2 □ Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)  |  | 20b. Best Estimate (Name of cemetery, crematory or other place)<br><b>Memorial Park</b>  | Date<br><b>4-30-12</b>   | 20c. Location - City or Town, State<br><b>Annapolis, Md.</b>                 |
| 21. Signature of Funeral Service Licensee<br><b>Larry Reese</b>  |  | Name and address of Facility<br><b>Reese &amp; Sons Mortuary, P.A.<br/>1922 Forest Dr. Annapolis, Md. 21401</b>  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>DEMENTIA</b>  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>years</b>   |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |  |
| <p>a. Due to (or as a consequence of):<br/><b>DEMENTIA</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown        |  | 23d. Date of delivery<br>Month Day Year                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>gangrene L foot due to severe AMEROSCLEROTIC DISEASE</b>  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 □ Yes 2 X No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 □ No  |  |  |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) <b>TATE House</b> |  |  |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 □ Yes 2 □ No                                       |
|  |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier<br>(Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Eva S. Herzen</b>  |  |  |
|  |  | 29c. License number<br><b>MD D0036581</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eva S. Herzen MD 445 Defense Hwy Annapolis MD 21401</b>   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 27 2012</b>  |  | 32. Registrar's Signature<br><b>Eva S. Herzen</b>  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15308

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 4 Day 29 Year 2012  |   | 3. Time of Death<br>2:57 P M  |
| Clinton Otto Worsham   |  |   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br>13337 Ocean Drive  |  | 4b. City, Town, or Location of Death<br>Ocean City  |   | 4c. County of Death<br>Worcester  |
| 5. Social Security Number<br>216-01-9521   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>95 Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br>9/8/1916   |
| Usual Residence of Decedent<br>10a. State<br>MD  |  | 10b. County<br>Worcester  |   | 10c. City, Town or Location<br>Ocean City   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |   |
| 10e. Street and Number<br>13337 Ocean Drive  |  | 10f. Zip Code<br>21842  |   | 10g. Citizen of What Country?<br>USA  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>white |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Accountant  |   | 16b. Kind of Business Industry<br>Accounting  |
| 17. Father's Name (First, Middle, Last)<br>Benjamin C. Worsham   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Luckan  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Antoinette Worsham /daughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13 Black Duck Reach, Rehoboth, DE 19971  |   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>► <i>John MacJocel</i>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>First State Crem.   |   | Date 5/1/2012   |
| 20c. Location - City or Town, State<br>Millsboro, DE   |  |   |   |   |
| 21. Signature of Funeral Service Licensee<br>► <i>John MacJocel</i>  |  | 22. Name and Address of Facility<br>Burbage Funeral Home<br>108 William St., Berlin, MD 21811   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br><i>Atherosclerotic Cardiovascular Disease</i><br>Approximate Interval Between Onset and Death<br><i>Years</i>   |  |   |   |   |
| b. Due to (or as a consequence of):  |  |   |   |   |
| c. Due to (or as a consequence of):  |  |   |   |   |
| d. Due to (or as a consequence of):  |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |
|  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |
| 29b. Signature and title of certifier<br>► <i>Nicholas Borodulka, md.</i>  |  | 29c. License number<br>C10001802  |   | 29d. Date signed (Month, Day, Year)<br>4 30 12  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Nicholas Borodulka, md. 1207 Coastal Highway Fenwick Island, De 19944  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 01 2012   |  | 32. Registrar's Signature<br><i>James S. Parker</i>   |   |   |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15309

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>C. Edward Walls</b>  |  |  |  | 2. Date of Death<br>Month: April Day: 27 Year: 2012  |  |   |  | 3. Time of Death<br>11:45P. M   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>3158 Gracefield Road, FC#516</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  |   |  | 4c. County of Death<br><b>Prince George's</b>                           |  |
| 5. Social Security Number<br><b>233-38-1758</b>   |  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>83 Yrs.</b> | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 6, 1929</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |   |  |
| Usual Residence of Decedent<br>10a. State<br><b>Maryland</b> 10b. County<br><b>Prince George's</b> 10c. City, Town or Location<br><b>Silver Spring</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |  |  |   |  |   |  |
| 10e. Street and Number<br><b>3158 Gracefield Road, FC#516</b>   |  |  |  | 10f. Zip Code<br><b>20904</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1951-1959</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreign Commercial Attache</b>                        |  | 16b. Kind of Business Industry<br><b>Department of Commerce</b>  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Connie Edward Walls</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Belvah Cook</b>  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores Walls -wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3158 Gracefield Road, FC516 Silver Spring, MD 20904</b>  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | Date<br><b>4/30/2012</b>   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, PA<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>   |  |   |  |   |  |

|  |  |                               |  |  |  |  |
|--|--|-------------------------------|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | <b>METASTATIC LUNG CANCER</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>2 YEARS</b> |
| <p>a. Due to (or as a consequence of):<br/> <br/>           b. Due to (or as a consequence of):<br/>           c. Due to (or as a consequence of):<br/>           d. _____</p>   |  |                               |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |                               |  |  |  |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year |  |
|---|--|---|--|--|--|---|--|

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |  |  |  |  |  |  |  |
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|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD |  |  |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|---|--|---|--|--|--|---|--|--|

|   |  |  |  |  |  |                                   |  |  |
|---|--|--|--|--|--|-----------------------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury  | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |  |  |
|   |  |  |  |  |  |                                   |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |  |

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D24093</b>                  |  |  |  |  |  |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>4/30/12</b> |  |  |  |  |  |  |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARK PARKHURST MD 3110 GRACEFIELD SILVER SPRING MD 20904</b> |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|

|   |  |                               |  |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b> |  | 32. Registrar's Signature<br> |  |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial permit.

15+1

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Funeral  
Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

15+1

DHMH 17 Rev 7/2009

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15310

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |  |  |   |   |  |                  |  |  |  |  |
|-------------------------------------|--|--|--|---|---|--|------------------|--|--|--|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)   |  |   |   | 2. Date of Death   |                  | 3. Time of Death   |  |  |  |
|                                     |  | <b>James O. Williams</b>   |  |   |   | Month <b>April</b> Day <b>24</b> Year <b>2012</b>  |                  | 5:30a M  |  |  |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)   |  |   |   | 4b. City, Town, or Location of Death   |                  | 4c. County of Death  |  |  |  |
|                                     |  | <b>Holy Cross Hospital</b>   |  |   |   | <b>Silver Spring</b>   |                  | <b>Montgomery</b>  |  |  |  |
| Funeral Director                    |  | 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. last birthday)  | If Under 1 Year   |  | If Under 24 Hrs. |  | 8. Date of Birth (Month, Day, Year)            | 9. Birthplace (State or Foreign Country)   |  |
|                                     |  | <b>246-48-9735</b>   | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                   | 78 Yrs.   | Months  | Days   | Hours            | Min.   | <b>10-11-1933</b>                              | <b>Franklin, NC</b>  |  |
| To Be Completed by Funeral Director |  | 10a. State   | 10b. County  | 10c. City, Town or Location   |   |  |                  |  |  | 10d. Inside City Limits  |  |
|                                     |  | <b>MD</b>  | <b>Prince George's</b>   | <b>Laurel</b>   |   |  |                  |  |  | <b>1X Yes 2 No</b>   |  |
|                                     |  | 10e. Street and Number   |  |   |   | 10f. Zip Code  |                  |  | 10g. Citizen of What Country?                  |  |  |
|                                     |  | <b>14829 Belle Ami Drive</b>   |  |   |   | <b>20707</b>   |                  |  | <b>United States</b>                           |  |  |
|                                     |  | 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                  |  | 14. Race - American Indian, Black, White, etc. |  |  |
|                                     |  | 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |                  |  | Specify: <b>Black</b>                          |  |  |
|                                     |  | 15. Decedent's Education (Specify only highest grade completed)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |                  | 16b. Kind of Business/Industry   |  |  |  |
|                                     |  | <b>Elementary/Secondary (0-12) 12</b>  |  |   | <b>Sewing Machine Technician</b>  |  |                  | <b>Private</b>   |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)  |                  |  |  |  |  |
|                                     |  | <b>Jessie Williams</b>   |  |   |   | <b>Rosa Richardson</b>   |                  |  |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)                |                  |  |  |  |  |
|                                     |  | <b>Mary L. Williams/ Wife</b>  |  |   |   | <b>14829 Belle Ami Drive Laurel, MD 20707</b>  |                  |  |  |  |  |
|                                     |  | 20a. Method of Disposition   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                    |  | Date             |  | 20c. Location - City or Town, State            |  |  |
|                                     |  | 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | <b>Fort Lincoln Crematory</b>   |  | <b>05-1-2012</b> |  | <b>Brentwood, MD</b>                           |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee  |  |   |   | 22. Name and Address of Facility   |                  |  |  |  |  |
|                                     |  |    |  |   |   | <b>Fort Lincoln Funeral Home</b>   |                  |  |  |  |  |
|                                     |  |  |  |   |   | <b>3401 Bladensburg Rd Brentwood MD 20722</b>  |                  |  |  |  |  |
|                                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |                  |  |  | Approximate Interval Between Onset and Death   |  |
|                                     |  | Immediate Cause (Final disease or condition resulting in death)  |  |   |   |  |                  |  |  |  |  |
|                                     |  | a. <u>Respiratory Failure</u><br>Due to (or as a consequence of):  |  |   |   |  |                  |  |  |  |  |
|                                     |  | b. <u>Pulmonary Fibrosis</u><br>Due to (or as a consequence of):   |  |   |   |  |                  |  |  |  |  |
|                                     |  | c. _____<br>Due to (or as a consequence of):   |  |   |   |  |                  |  |  |  |  |
|                                     |  | d. _____   |  |   |   |  |                  |  |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |   |  |                  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b>  |  |   |   |  |                  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury M  |                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|                                     |  |  |  |   |   |  |                  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|                                     |  |  |  |   |   |  |                  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|                                     |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |                  |  |  |  |  |
|                                     |  | 29b. Signature and title of certifier<br>   |  | <b>MD</b>   |   | 29c. License number  |                  | 29d. Date signed (Month, Day, Year)  |  |  |  |
|                                     |  |  |  |   |   | <b>D0063343</b>  |                  | <b>04/25/2012</b>  |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |   |  |                  |  |  |  |  |
|                                     |  | <b>Charu Maheshwary MD. 1500 Forest Glen Rd. Silver Spring, MD 20910</b>   |  |   |   |  |                  |  |  |  |  |
| State Registrar                     |  | 31. Date filed (Month, Day, Year)  |  | 32. Registrar's Signature   |   |  |                  |  |  |  |  |
|                                     |  | <b>MAY 01 2012</b>   |  |    |   |  |                  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 1531

1 - For  
State  
Registrar

|  |  |   |  |  |   |   |  |  |
|--|--|---|--|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FRANKLIN E. WINT</b>  |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 19, 2012</b>         | 3. Time of Death<br>6:40 PM  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Potomac Valley Nursing/Wellness Ctr</b>   |   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>                     |   | 4c. County of Death<br><b>Montgomery</b>                            |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-48-1412</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>84</b><br>Yrs.  | If Under 1 Year<br>Months Days Hours Min.                                    | 8. Date of Birth<br>(Month, Day, Year)<br><b>9-20-1927</b>  | 9. Birthplace (State or Foreign Country)<br><b>White Plains, NY</b> |  |  |
|  | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Montgomery</b>  |   |  | 10c. City, Town or Location<br><b>Rockville</b>                              |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>1235 Potomac Valley Rd</b>  |   |  | 10f. Zip Code<br><b>20850</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>               |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12) <b>4</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Researcher</b>                          |  | 16b. Kind of Business Industry<br><b>Library of Congress</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas Wint</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Groset</b>     |   |   |  |  |
| Physician/<br>Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thompkins W. Hallman (friend)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1801 Clydesdale Place NW #320 Washington, DC 20009</b> |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Fort Lincoln Crematory</b>       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>5/14/12</b>   |  | Date  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>         |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner   | 21. Signature of Funeral Service Licensee<br><b>Brooks Barnes</b>  |   | 22. Name and Address of Facility <b>Fort Lincoln Funeral Home</b><br><b>3401 Bladensburg Rd. Brentwood, MD 20722</b>                                       |  |   |   |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (final disease or condition resulting in death) |   | 23b. Due to (or as a consequence of):<br><b>Cerebro Vascular Accident</b><br>Approximate Interval Between Onset and Death<br><b>10 days</b>                |  |   |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                                   |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr A mendhiratta MD</b>  |  | 29c. License number<br><b>D38262</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 19, 2012</b>                 |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr A mendhiratta 9043 Shady Grove Hospital Rockville MD 20877</b>   |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 01 2012</b>  |  | 32. Registrar's Signature<br><b>A. Garcia</b>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Case # 12-3348

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15312

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |   |                                |   |  |  |  |   |  |  |  |
|--|--|---|--------------------------------|---|--|--|--|---|--|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)  |                                |   |  | 2. Date of Death   |  | 3. Time of Death  |  |  |  |
|  |  | Jason Yonker  |                                |   |  | Month 4 Day 30 Year 2012   |  | 04 15 AM  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | University of Maryland - Shock Trauma Ctr   |                                |   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death   |  |  |  |
|  |  |   |                                |   |  | Baltimore, MD  |  | Baltimore   |  |  |  |
| 5. Social Security Number  |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year   |  | If Under 24 Hrs.   |  | 8. Date of Birth  |  |  |  |
| 215-94-6185  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 33 Yrs.                        | Months  |  | Hours  |  | Month, Day, Year  |  |  |  |
| Usual Residence of Decedent  |  |   |                                |   |  |  |  | Sept. 19, 1978  |  |  |  |
| 10a. State   |  | 10b. County   |                                | 10c. City, Town or Location   |  |  |  | 9. Birthplace (State or Foreign Country)  |  |  |  |
| Maryland   |  | Washington  |                                | Williamsport  |  |  |  | Maryland  |  |  |  |
| 10d. Inside City Limits  |  |   |                                |   |  |  |  |   |  |  |  |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                                |   |  |  |  |   |  |  |  |
| 10e. Street and Number   |  | 10f. Zip Code   |                                |   |  | 10g. Citizen of What Country?  |  |   |  |  |  |
| 15926 Falling Waters Road  |  | 21795   |                                |   |  | USA  |  |   |  |  |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  |  |  |  | 14. Race - American Indian, Black, White, etc.  |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | Specify: white  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                |   |  | 16b. Kind of Business/Industry   |  |   |  |  |  |
| Elementary/Secondary (0-12) 12   |  | College (1-4 or 5+) 1   |                                | supervisor/truck driver   |  |  |  | site work   |  |  |  |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |   |  |  |  |   |  |  |  |
| Robert Edward Yonker   |  | Loretta Marie Nazelrod  |                                |   |  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |   |  |  |  |   |  |  |  |
| Crystal Yonker - wife  |  | 15926 Falling Waters Rd., Williamsport, Md. 21795   |                                |   |  |  |  |   |  |  |  |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date  |  | 20c. Location - City or Town, State  |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Cedar Lawn Mem. Park  |                                | 5/4/12  |  | Hagerstown, Maryland   |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility  |                                |   |  |  |  |   |  |  |  |
|  |  | MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |                                |   |  |  |  |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |                                |   |  | Approximate Interval Between Onset and Death   |  |   |  |  |  |
| a. <u>Multiple Injuries</u><br>Due to (or as a consequence of):  |  |   |                                |   |  | 48hr   |  |   |  |  |  |
| b. <u>Motor Vehicle Injuries/Accident</u><br>Due to (or as a consequence of):  |  |   |                                |   |  |  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |                                |   |  |  |  |   |  |  |  |
| d.   |  |   |                                |   |  |  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |                                | 23d. Date of delivery<br>Month Day Year   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |  |  |
|  |  |   |                                |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |                                | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br>4/28/2012   |                                | 28b. Time of injury<br>0421 AM  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><i>MVC and then it was struck by MV - exiting</i>                          |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Street  |                                |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>RT 270 and RT 85, Frederick, Co |  |  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><br>MD  |  | 29c. License number<br>101388   |                                |   |  | 29d. Date signed (Month, Day, Year)<br>4/30/12   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |                                |   |  |  |  |   |  |  |  |
| K. Nagarsheth MD 22 South Greene St. Baltimore, MD 21201   |  |   |                                |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 08 2012   |  | 32. Registrar's Signature<br>   |                                |   |  |  |  |   |  |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 15313

1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

|  |                           |  |  |                                 |
|--|---------------------------|--|--|---------------------------------|
| 1. Decedent's Name (First, Middle, Last)                       | John Joseph Zaniewski     |  | 2. Date of Death<br>Month Day Year                   | 3. Time of Death<br>1220AM      |
| 4a. Facility Name (if not institution, give street and number) | COSTA HOSPICE AT THE LAKE |  | 4b. City, Town, or Location of Death<br>Salisbury MD | 4c. County of Death<br>Wicomico |

Funeral  
Director

|                           |  |   |   |   |  |
|---------------------------|--|---|---|---|--|
| 5. Social Security Number | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>69 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>8/22/1942 | 9. Birthplace (State or Foreign Country)<br>PA |
|---------------------------|--|---|---|---|--|

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|                  |                          |  |  |
|------------------|--------------------------|--|--|
| 10a. State<br>MD | 10b. County<br>Worcester | 10c. City, Town or Location<br>Ocean Pines | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|------------------|--------------------------|--|--|

|   |                        |                                      |
|---|------------------------|--------------------------------------|
| 10e. Street and Number<br>24 Hingham Lane | 10f. Zip Code<br>21811 | 10g. Citizen of What Country?<br>USA |
|---|------------------------|--------------------------------------|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: white |
|--|---|--|--|

|   |   |  |
|---|---|--|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>5+ | 16b. Kind of Business Industry<br>Optical Engineer |
|---|---|--|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>Jan Zaniewski | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Frances Rajnik |
|--|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Adele Zaniewski / wife | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24 Hingham Lane, Ocean Pines, MD 21811 |
|--|---|

|   |   |                 |  |
|---|---|-----------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>First State Crem. | Date<br>4/30/12 | 20c. Location - City or Town, State<br>Millsboro, DE |
|---|---|-----------------|--|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br>► W. Eric Burbage | 22. Name and Address of Facility<br>Burbage Funeral Home<br>108 William St., Berlin, MD 21811 |
|--|---|

Physician/  
Medical  
Examiner

|  |  |  |
|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | 23b. Due to (or as a consequence of):<br>BLADDER CANCER WITH BONE METASTASIS | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a consequence of):  |  |
| c. Due to (or as a consequence of):  | d. Due to (or as a consequence of):  |  |

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|---|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice |
|---|--|

|  |  |                          |  |                                   |
|--|--|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | 28a. Date of injury (Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |  |  |  |
|--|--|--|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Physician<br>2 <input type="checkbox"/> Medical Examiner<br>3 <input type="checkbox"/> Certifying Nurse Practitioner | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
|--|--|--|--|

|  |                                 |   |
|--|---------------------------------|---|
| 29b. Signature and title of certifier<br>► | 29c. License number<br>DC058410 | 29d. Date signed (Month, Day, Year)<br>04/26/12 |
|--|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G. HUNTER WALK JR. M.D. 1733 SALISBURY RD 21802 |
|---|

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>APR 30 2012 | 32. Registrar's Signature<br>Leanne S. Farren |
|--|---|

Division of Vital Records, P.O. Box 68760

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

John Zaniewski  
Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15314

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

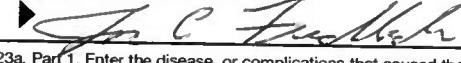
Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |                        |   |   |   |  |  |  |  |   |
|---|------------------------|---|---|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)  |                        | 2. Date of Death<br>Month 05 Day 2 Year 2012  |   |   |  | 3. Time of Death<br>5:00 PM  |  |  |   |
| William Andrew Zang, Sr.  |                        |   |   |   |  |  |  |  |   |
| 4a. Facility Name (if not institution, give street and number)<br>Goodwill Mennonite Nursing Home   |                        | 4b. City, Town, or Location of Death<br>Grantsville   |   |   |  | 4c. County of Death<br>Garrett   |  |  |   |
| 5. Social Security Number<br>220-32-3673<br>Usual Residence of Decedent   |                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75 Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>12/19/1936   | 9. Birthplace (State or Foreign Country)<br>MD                   |  |   |
| 10a. State<br>MD  | 10b. County<br>Garrett | 10c. City, Town or Location<br>Oakland  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |
| 10e. Street and Number<br>237 Cheeks Lane   |                        |   | 10f. Zip Code<br>21550  |   |  | 10g. Citizen of What Country?<br>USA   |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. 1955 - 1958   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |                        | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Auto Worker   |   | 16b. Kind of Business/Industry<br>Manufacturing   |  |  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Albert H. Zang   |                        |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Iva B. Lewis   |  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Debra M. Shannahan / Daughter   |                        |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>204 Leslie Ave., Baltimore, MD 21236 |   |  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                        |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Taylor Sines Cemetery                                       |   |  | Date<br>5/5/2012   | 20c. Location - City or Town, State<br>Oakland, MD               |  |   |
| 21. Signature of Funeral Service Licensee<br>  |                        |   | 22. Name and Address of Facility<br>Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550                     |   |  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.<br>shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                        |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>6 days   |   |
| <p>a. <b>Acute viral respiratory infection</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |                        |   |   |   |  |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |                        | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |   |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia, hyponatremia, eosinophilia  |                        |   |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
|   |                        |   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |                        | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |  |   |
|   |                        | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                        | 29c. License number<br>D26650   |   |   |  |  |  | 29d. Date signed (Month, Day, Year)<br>5/3/2012  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Margaret A. Kaiser, MD, 13079 Garrett Highway, Oakland, MD 21550  |                        |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY - 4 2012</b>  |                        |   |   |   |  |  |  | 32. Registrar's Signature<br>   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15315

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|                                     |  |   |   |   |  |  |  |  |  |  |  |
|-------------------------------------|--|---|---|---|--|--|--|--|--|--|--|
| 1 - For<br>State<br>Registrar       |  | 1. Decedent's Name (First, Middle, Last)<br><b>Ruben J. Aguiniga</b>  |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>12</b> Year <b>2012</b>  |  | 3. Time of Death<br>P M <b>3:30</b>  |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist of Columbia</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>   |  |  |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>554-93-7340</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>26</b> Yrs.  | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/>   | If Under 24 Hrs.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 24, 1985</b>             | 9. Birthplace (State or Foreign Country)<br><b>Mexico</b>  |  |  |  |
| To Be Completed by Funeral Director |  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Howard</b>  | 10c. City, Town or Location<br><b>Ellicott City</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|                                     |  | 10e. Street and Number<br><b>8894 Town and Country Blvd.</b>  |   |   |  | 10f. Zip Code<br><b>21043</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
|                                     |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Specify: <b>Mexican</b> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b> |  |  |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>                      |  |  | 16b. Kind of Business/Industry<br><b>Production Plant</b>  |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Jorge M. Aguiniga</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marcia Rios</b>  |  |  |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marcia Aguiniga / Mother</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8894 Town and Country Blvd., Ellicott City, MD 21043</b> |  |  |  |  |  |  |
|                                     |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Metro Crematory Inc.</b>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc.</b>  |  | Date<br><b>05/14/2012</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><b>Alyson K Taylor</b>   |   |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland Inc</b><br><b>299 Frederick Road, Baltimore, Maryland 21228</b>                         |  |  |  |  |  |  |
|                                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>NASOPHARYNGEAL CANCER</b>  |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>MONTHS</b>  |  |
|                                     |  | a. Due to (or as a consequence of):<br><b>{</b>   |   |   |  |  |  |  |  |  |  |
|                                     |  | b. Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |  |
|                                     |  | c. Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |  |
|                                     |  | d. Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                             |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>METASTATIC SQUAMOUS CELL NASOPHARYNGEAL CANCER</b><br><b>AIRWAY OBSTRUCTION SECONDARY TO CANCER</b><br><b>MALNUTRITION, HERPES</b>   |   |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                     |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br><b>INPATIENT UNIT</b> |  |  |  | 23f. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|                                     |  | 27. Manner of Death<br><b>Natural</b><br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |  |  |  |
|                                     |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |  |  |  |  |
|                                     |  | 29b. Signature and title of certifier<br><b>Fatima A. Naqvi, MD</b>   |   | 29c. License number<br><b>DOCE69962</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/12/12</b>  |  |  |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FATIMA A. NAQVI, 6334 CEDAR LANE, COLUMBIA, 21044, MD</b>  |   |   |  |  |  |  |  |  |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   | 32. Registrar's Signature<br><b>Seema J. Patel</b>  |  |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, per FH, G927, 5/22/2012, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15316

1 - For State Registrar

|   |  |  |   |   |  |   |  |  |
|---|--|--|---|---|--|---|--|--|
| Physician /Medical Examiner                   | 1. Decedent's Name (First, Middle, Last)<br><b>Jean Arnold</b>   |  |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>2</b> Year <b>2012</b>   | 3. Time of Death<br><b>2557 M</b>                                       |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST AGNES HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death  |   |  |  |
| Funeral Director                              | 5. Social Security Number<br><b>232-52-3418</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>81</b><br>Yrs.   | If Under 1 Year<br>Months <b>12</b> Days <b>04</b> Hours <b>30</b> Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>12 04 30</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>3300 Alto Road</b>  |  |   | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1980</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Ukn</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Receptionist</b>   |   | 16b. Kind of Business/Industry<br><b>Johns Hopkins Hospital</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ron Green-Care Giver</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3300 Alto Road, Baltimore, Md 21216</b>   |  |   |  |  |
| Physician /Medical Examiner                   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ukm</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Carmel</b>   |   | Date <b>Ukm</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Md</b>             |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Glynne B. Kekke</b>  |  |   | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, Md 21215</b>  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEVERE DEMENTIA</b>   |  |   |   |  |   |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>SEIZURE DISORDERS</b>   |  |   |   |  |   |  |  |
|   | Approximate Interval Between Onset and Death<br><b>UNKNOWN</b>   |  |   |   |  |   |  |  |
|   | 23b. If Female:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>Unknown</b>                      |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>  |  |   |   |  |   |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>28b. Time of Injury<br/>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred                                       |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  |   |   |  |   |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore MD 21229</b>  |  |   |   |  |   |  |  |
|   | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |  |  |
|   | 29b. Signature and title of certifier<br><b>ATTENDING</b>  |  | 29c. License number<br><b>DOS56948</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 2 2012</b>   |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES TAMIINDA 3455 WILSON AVE #204 BALTIMORE MD 21229</b>  |  |   |   |  |   |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Susan B. Kekke</b>  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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 ammend #6&8 Per INF G932 10/02/2012 JH  
 State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

**Certificate of Death**

Reg. No.

2012 15317

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical  
Examiner**

To Be Completed by Physician/Medical Examiner

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 5 Day 13 Year 12 1:30 A.M.  |   | 3. Time of Death   |
| <i>Robert Charles Atkinson</i>   |  |   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>VA Loch Raven CLC</i>   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |   | 4c. County of Death<br>—   |
| 5. Social Security Number<br><i>054-48-9730</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><i>59 56</i> Yrs.   | If Under 1 Year      If Under 24 Hrs.<br>Months      Days      Hours      Min.         |
|  |  |   |   |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><i>04/17/1956</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>New York</i>   |   |  |
| 10a. State<br><i>MD</i>  |  | 10b. County<br><i>Anne Arundel</i>  | 10c. City, Town or Location<br><i>Glen Burnie</i>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 10e. Street and Number<br><i>96 Foxwell Bend Road</i>  |  | 10f. Zip Code<br><i>21061</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i>White</i> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Seconday (0-12)</i>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Colonel</i>  | 16b. Kind of Business Industry<br><i>Government</i>   |  |
| 17. Father's Name (First, Middle, Last)<br><i>James Franklin Atkinson</i>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Dorothy Elizabeth Anders</i>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Jeanette Atkinson / Spouse</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>96 Foxwell Bend Rd., Glen Burnie, MD 21061</i>  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>[Signature]</i>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Anatomy Gifts Registry</i>   | Date<br><i>05/15/2012</i>   | 20c. Location - City or Town, State<br><i>Hanover, Maryland</i>                        |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility Anatomy Gifts Registry<br><i>7522 Connellley Dr., Ste. P, Hanover, MD 21076</i>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><i>Glioblastoma Multiforme</i>  |  |   |   |  |
| Approximate Interval Between Onset and Death<br><i>unknow</i>  |  |   |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |
| 24a. Was an autopsy performed<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of injury   | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |
|  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><i>34359</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>5 13 12</i>                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>John S. Lap, m.d.</i>   |  | 3900 Loch Raven Blvd Baltimore, MD 21218  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 15 2012</i>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |

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State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15318

**1- For State Registrar****Physician/  
Medical Examiner**

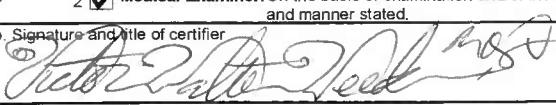
|  |   |  |                                       |  |                   |                  |  |   |
|--|---|--|---------------------------------------|--|-------------------|------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Terrence Anderson</b>                         |   |  |                                       | 2. Date of Death<br>Month Day Year<br><b>May 8, 2012</b> |                   |                  | 3. Time of Death<br><b>1455 hrs</b>              |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>University Hospital</b> |   |  |                                       | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |                   |                  | 4c. County of Death<br><b>NA</b>                 |   |
| 5. Social Security Number<br><b>212-37-5516</b>  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>19 Yrs.</b> | If Under 1 Year<br>Months<br><b>0</b> | If Under 24 Hrs.<br>Days<br><b>0</b>                     | Hours<br><b>0</b> | Min.<br><b>0</b> | 8. Date of Birth (MM/DD/YYYY)<br><b>07-07-92</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |

**Funeral Director****To Be Completed by Funeral Director**

**Baltimore, MD 21215-0036**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|   |  |   |  |  |   |  |   |  |  |   |
|---|--|---|--|--|---|--|---|--|--|---|
| Usual Residence of Decedent<br>10a. State<br><b>MD</b>  |  |   |  | 10b. County<br><b>NA</b>   |   |  | 10c. City, Town or Location<br><b>Baltimore</b> |  |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
| 10e. Street and Number<br><b>3814 Old Frederick Road</b>  |  |   |  | 10f. Zip Code<br><b>21229</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b>     |  |  |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>If Yes, Give Year or Dates: |   | 14. Race - American Indian, Black, White, etc.<br><b>African</b> |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10th Grade</b>   |  | College (1-4 or 5+)<br><b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |   | 16b. Kind of Business/Industry<br><b>Construction Co.</b>        |   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Terry Anderson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anita Butler</b>   |   |  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anita Butler-Mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3814 Old Frederick Road Baltimore, Maryland 21229</b>  |   |  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cem.</b>  |  | Date<br><b>05-17-12</b>  | 20c. Location - City or Town, State<br><b>Lansdowne, MD</b>                                     |  |   |  |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Sherelle Simpson</b>  |  |   |  | 22. Name and Address of Facility<br><b>Wylie Funeral Home P.A.<br/>638 N. Gilmor Street Baltimore, Maryland 21217</b>  |   |  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death   |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Gunshot Wound of Head</b><br>Due to (or as a consequence of):  |  |   |  |  |   |  |   |  |  |   |
| b. _____<br>Due to (or as a consequence of):  |  |   |  |  |   |  |   |  |  |   |
| c. _____<br>Due to (or as a consequence of):  |  |   |  |  |   |  |   |  |  |   |
| d. _____  |  |   |  |  |   |  |   |  |  |   |
| <input type="checkbox"/> UNPENDED   |  | <input type="checkbox"/> AMENDED  |  |  |   |  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |  |   |  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
|   |  |   |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:  |   |  |   |  |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>May 6, 2012</b>   |  | 28b. Time of Injury<br><b>0247 hrs</b>   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Subject shot</b>         |   |  |  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br><b>Sidewalk</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>600 North Eutaw Street, Baltimore, MD</b>   |   |  |   |  |  |   |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |  |   |  |  |   |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |   |  |  |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>May 11, 2012</b>   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  |   |  | 32. Registrar's Signature<br>   |   |  |   |  |  |   |

*EW***Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State Registrar**

Robert Hasani Mack Bond

12-03506

UNK UNK

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15319

**1-For State Registrar**

1. Decedent's Name (First, Middle, Last)

Robert Mack Bond

2. Date of Death

Month Day Year

May 6, 2012

3. Time of Death

1525 hrs

**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

4. Facility Name (if not institution, give street and number)

3007 Oakley Ave

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-29-8760

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

21

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

11/1/1990

9. Birthplace (State or Foreign Country)

MD

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

7008 Marietta Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Robert Bond Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Stacey White

19a. Informant's Name/Relationship (Type, Print)

Stacey White Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7008 Marietta Ave. Baltimore, MD 21234

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Pk.

Date

5/15/2012 Randallstown, MD

21. Signature of Funeral Service Licensee

B. C. J. H.

22. Name and Address of Facility

March F/H-East 1101 E.

North Ave. Baltimore, MD 21202

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds of Head and Neck

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes 2  NoHospital: 1  Inpatient 2  ER/Outpatient 3  DOA

26. Place of Death (Check only one)

4  Nursing Home 5  Residence 6  Other: Scene

27. Manner of Death

1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide7  Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: May 6, 2012

28b. Time of Injury

FOUND: 1520 hrs

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Specify) Townhouse / Rowhouse

3007 Oakley Ave, Baltimore, MD

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. M. E.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 7, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

James S. Parker

**State  
Registrar****ORIGINAL**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15320

**1- For State Registrar****Physician/  
Medical Examiner**

|  |  |  |  |   |  |  |  |   |
|--|--|--|--|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>RUTH BRABOY</b>                                       |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 28, 2012</b> |  |  |  | 3. Time of Death<br><b>1857 hrs</b>           |
| 4a. Facility Name (if not institution, give street and number)<br><b>Volta<br/>9018 Volta Street</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>       |  |  |  | 4c. County of Death<br><b>Prince George's</b> |

**Funeral Director**

|   |   |  |                                       |                                     |  |   |
|---|---|--|---------------------------------------|-------------------------------------|--|---|
| 5. Social Security Number<br><b>218-20-2125</b> | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>85 Yrs.</b> | If Under 1 Year<br>Months<br><b> </b> | If Under 24Hrs.<br>Days<br><b> </b> | 8. Date of Birth (MM/DD/YYYY)<br><b>08/13/1926</b> | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b> |
|---|---|--|---------------------------------------|-------------------------------------|--|---|

**To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 2a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |  |  |                                       |  |  |  |   |   |
|--|--|--|--|---------------------------------------|--|--|--|---|---|
| Usual Residence of Decedent<br>10a. State<br><b>MARYLAND</b> |  |  |  | 10b. County<br><b>PRINCE GEORGE'S</b> |  |  |  | 10c. City, Town or Location<br><b>LANHAM</b>          | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
| 10e. Street and Number<br><b>9018 VOLTA STREET</b>           |  |  |  | 10f. Zip Code<br><b>20706</b>         |  |  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b> |   |

|  |   |   |   |
|--|---|---|---|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |
|--|---|---|---|

|  |   |   |
|--|---|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>3 | 16b. Kind of Business/Industry<br><b>ADMINISTRATIVE ASSISTANT</b> |
|--|---|---|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL JONES</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE JACKSON</b> |
|---|---|

|   |   |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MICHAEL BRABOY / SON</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9018 VOLTA STREET, LANHAM, MARYLAND 20706</b> |
|---|---|

|  |   |                          |  |
|--|---|--------------------------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY CEMETERY</b> | Date<br><b>5/10/2012</b> | 20c. Location - City or Town, State<br><b>LANDOVER, MARYLAND</b> |
|--|---|--------------------------|--|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br><i>MSB</i> | 22. Name and Address of Facility<br><b>JB JENKINS FUNERAL HOME, INC.</b><br><b>7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20708</b> |
|---|--|

**Physician/  
Medical Examiner**

|   |  |  |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute bronchopneumonia complicating Metastatic carcinoma to the brain</b> |  | Approximate Interval Between Onset and Death<br> |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>  |  |  |
| b. Due to (or as a consequence of):<br>   |  |  |
| c. Due to (or as a consequence of):<br>   |  |  |
| d. <b>UNPENDED</b> <b>AMENDED 23a, pt. II, 27, per me, g928 6-22-12 sm #4a, per ME, G929, 7/12/2012, WS</b>   |  |  |

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End-Stage renal Disease; cachexia</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |  |
|---|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|--|--|

|   |   |                                   |
|---|---|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|---|---|-----------------------------------|

|   |  |
|---|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|--|

|   |  |  |  |
|---|--|--|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated<br>one<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Ana Rubio MD</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>April 29, 2012</b> |
|---|--|--|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><i>Bruce J. Farber</i> |
|---|---|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1532

For  
State  
Registrar

1-

Physician/  
Medical  
Examiner

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Grace Virginia Boston</b>  |  | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> , Year <b>2012</b>   |  | 3. Time of Death<br><b>3:35 PM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                      |
| 5. Social Security Number<br><b>216-30-7893</b>   |  | 6. Sex<br><b>1 □ M 2 X F</b>  | 7. Age (in yrs. last birthday)<br><b>78 Yrs.</b>   | If Under 1 Year<br>Months      If Under 24 Hrs.<br>Days      Hours      Min. |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 25, 1934</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD Baltimore,</b>  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Bel Air</b>  |  |
| 10e. Street and Number<br><b>301 Althea Ct.</b>   |  | 10f. Zip Code<br><b>21015</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |
| 11. Marital Status<br><b>1 □ Never Married 2 □ Married<br/>3 X Widowed 4 □ Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No</b><br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 □ Yes 2 X No</b> Specify:<br><br><b>White</b> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>Own Home</b>                            |
| 17. Father's Name (First, Middle, Last)<br><b>Solon Frederick Updegraff</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Elizabeth Minick</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robbin Allison (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11948 Hartley Mill Road, Glen Arm, Maryland 21057</b>                 |  |  |
| 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem.</b>  | Date<br><b>May 16, 2012</b>  | 20c. Location - City or Town, State<br><b>Rosedale, Maryland</b>             |
| 21. Signature of Funeral Service Licensee<br><b>Jeffrey R. Testerman (M01543)</b>   |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services - Bel Air<br/>3 Newport Dr. Forest Hill, Maryland 21050</b>                          |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | <i>Sequel Stages COPD</i>   |  | Approximate Interval Between Onset and Death<br><i>unknown</i>               |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No 9 □ Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b>    |  | 23d. Date of delivery<br>Month Day Year                                      |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 X Yes 2 □ No 3 □ Probably 4 □ Unknown</b>  |  |   |  |  |
| 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Hospital</b> |  |  |
| 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide<br/>4 □ Homicide</b>   |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>MD</b>  | 28b. Time of injury<br><b>M</b>  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>                                |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |
| 29a. Certifier<br>(Check only one)<br><b>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29b. Signature and title of certifier<br><b>APATHI KUMAR MD</b>   |  | 29c. License number<br><b>D71040</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5 / 13 / 12</b>                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>APATHI KUMAR 6701 N CHARLES ST SUITE 4105 BALTIMORE MD</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><b>Seneca P. Parker</b>  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

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|                    |  |
|--------------------|--|
| State Registrar    |  |
| DHMH 17 Rev 7/2009 |  |

ORIGINAL

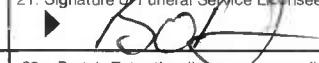
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15322

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sol Shlomo Barsever</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>1720 P M</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>12108 Hunters Lane</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| 5. Social Security Number<br><b>218-06-0075</b><br>Usual Residence of Decedent   |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>64 Yrs.</b> | 8. If Under 1 Year<br>Months      Days      Hours      Min.<br>If Under 24 Hrs.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>01/12/1948</b>   | 9. Birthplace (State or Foreign Country)<br><b>Israel</b>       |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>  |   |
| 10e. Street and Number<br><b>12108 Hunters Lane</b>  |  | 10f. Zip Code<br><b>20852</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br/>White</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Business Executive</b>   |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Matti Barsever</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Altooga Avneri</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Batia Barsever / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12108 Hunters Lane, Rockville, MD 20852</b>   |  |  |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Anatomy Gifts Registry</b>   |  | Date<br><b>05/15/2012</b>  | 20c. Location - City or Town, State<br><b>Hanover, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Anatomy Gifts Registry<br/>7522 Connelley Dr., Ste. P, Hanover, MD 21076</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>17 months</b>  |  |  |   |
| a. Due to (or as a consequence of):<br><b>Metastatic Non-Small Cell Lung Cancer</b>  |  |   |  |  |   |
| b. Due to (or as a consequence of):  |  |   |  |  |   |
| c. Due to (or as a consequence of):  |  |   |  |  |   |
| d. Due to (or as a consequence of):  |  |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>      |  | 23d. Date of delivery<br>Month      Day      Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>  |   |
|  |  |   |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |  |   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br><b>M</b>                  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  | 28d. Describe how injury occurred                               |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>MD060335</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 14 2012</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Barner 1811 Prince Philip Drive # 327 Olney, MD 20832</b>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |   |

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15323

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |  |  |   |  |  |   |  |   |  |  |
|--|--|--|--|---|--|--|---|--|---|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><i>Harriet Broadus</i>   |  |   |  |  |   | 2. Date of Death<br>Month Day Year<br><i>05 11 2012</i>  |   | 3. Time of Death<br><i>02:00</i>   |  |
|  |  | 4a. Facility Name (If not institution, give street and number)<br><i>Sinai Hospital</i>  |  |   | 4b. City, Town or Location of Death<br><i>Baltimore, MD</i>  |  |   | 4c. County of Death<br><i>NA</i>   |   |  |  |
|  |  | 5. Social Security Number<br><i>213-32-8730</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>100 Yrs.</i>  |  | If Under 1 Year<br>Months Days Hours Min.   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>03-17-12</i> | 9. Birthplace (State or Foreign Country)<br><i>VA</i>  |  |
|  |  | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>NA</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 10e. Street and Number<br><i>4009 Primrose Avenue</i>  |  |   |  | 10f. Zip Code<br><i>21216</i>  |   |  | 10g. Citizen of What Country?<br><i>USA</i>               |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><i>19XX No</i>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><i>African American</i> |  |   | 14. Race - American Indian, Black, White, etc.<br><i>African American</i>  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 11th Grade</i>  |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Domestic</i>                        |   |  | 16b. Kind of Business/Industry<br><i>other homes</i>      |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><i>Robert J. Betts</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Martha M. Betts</i>  |   |  |   |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Betty Webb-Daughter</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4009 Primrose Avenue Baltimore, Maryland 21215</i> |   |  |   |  |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>King Mem. Park Cem.</i>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>King Mem. Park Cem.</i> |  | Date<br><i>05-18-12</i>   | 20c. Location - City or Town, State<br><i>Randallstown, MD</i>   |   |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br><i>Shawna Thompson</i>  |  |   |  | 22. Name and Address of Facility<br>Wylie Funeral Home P.A.<br><i>638 N. Gilmor Street Baltimore, Maryland 21217</i>                                   |   |  |   |  |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Pneumonia</i>   |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death   |  |
|  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last<br><i>Congestive Heart Failure</i>  |  |   |  |  |   |  |   |  |  |
|  |  | a. Due to (or as a consequence of):<br><i>Pneumonia</i>  |  | b. Due to (or as a consequence of):<br><i>Congestive Heart Failure</i>  |  | c. Due to (or as a consequence of):<br><i></i>   |   | d. Due to (or as a consequence of):<br><i></i>   |   |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes Mellitus, Aortic Stenosis</i>  |  |   |  |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  | Other:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                            |   | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><i></i>   |  | 28b. Time of injury<br><i>M</i>  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  |  |
|  |  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i></i>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i></i>  |   |  |   |  |  |
|  |  | 29b. Signature and title of certifier<br><i>Anthony D. Thomas MD</i>   |  | 29c. License number<br><i>D46374</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>5/11/2012</i>  |   |  |   |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Anthony D. Thomas MD 2401 W Belvedere Ave Baltimore MD</i>  |  | 32. Registrar's Signature<br><i>Anna S. Parker</i>  |  | 31. Date filed (Month, Day, Year)<br><i>MAY 15 2012</i>  |   |  |   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene  
25,27,28a-f pr me, g927,05/11/2012dhb  
*Certificate of Death* Reg. No.

Reg. No. \_\_\_\_\_

2012 15324

|  |  |  |  |   |   |  |   |   |   |   |  |
|--|--|--|--|---|---|--|---|---|---|---|--|
| Physician/<br>Medical<br>Examiner  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald Owen Buchanan</b>  |  |   |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>25, 2012</b> Year         |   | 3. Time of Death<br><b>3:10 PM</b>                            |  |
| Funeral<br>Director  |  | 4a. Facility Name (If not institution, give street and number)<br><b>Meritus Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  |   | 4c. County of Death<br><b>Washington</b>                                |   |   |  |
| To Be Completed by Funeral Director  |  | 5. Social Security Number<br><b>406-52-0290</b>  |  | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>73 Yrs.</b>  |  | If Under 1 Year<br>Months                                   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month Day, Year)<br><b>6/27/1938</b> | 9. Birthplace (State or Foreign Country)<br><b>KY</b>         |  |
|  |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Hagerstown</b>   |   | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>                        |   |   |  |
|  |  | 10e. Street and Number<br><b>502 Road Island Avenue</b>  |  |   | 10f. Zip Code<br><b>21740</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |   |  |
|  |  | 11. Marital Status<br>1 □ Never Married 2 □ Married<br>3 □ Widowed 4 X Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 □ Yes 2 X No<br>If Yes, Give Year or Dates.<br>Elementary/Secondary (0-12) <b>12</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X No Specify:<br>15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |   |  |
|  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>labor</b>   |  | 16b. Kind of Business/Industry<br><b>Paper mill</b>   |   |  |   |   |   |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Chanceford Owen Buchanan</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Jones</b>   |  |   |   |   |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Greta Shelbourne, daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>626 Oakcrest, Paducah, KY 42001</b> |  |   |   |   |   |  |
|  |  | 20a. Method of Disposition<br>1 X Burial 2 □ Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)<br>► <b>Burial</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wickliffe City Cem.</b>  |   | Date<br><b>4/29/2012</b>   | 20c. Location - City or Town, State<br><b>Wickliffe, KY</b> |   |   |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Timothy Harman</b>   |  |   | 22. Name and Address of Facility<br><b>Harman Funeral Service, PA</b>   |  |   |   |   |   |  |
|  |  |  |  |   | 7221 Grayburn Drive, Glen Burnie, MD 21061  |  |   |   |   |   |  |
| Physician/<br>Medical<br>Examiner  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   |   |   | Approximate Interval Between Onset and Death<br><b>Jan 27</b> |  |
|  |  | <p>a. Due to (or as a consequence of):<br/><b>Pneumonia</b></p> <p>b. Due to (or as a consequence of):<br/><b>dysphagia</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>   |  |   |   |  |   |   |   |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown                             |   | 23d. Date of delivery<br>Month Day Year  |   |   |   |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Urinary tract infections, Diabetes mellitus. Quadriplegia. Hypertension</b>   |  |   |   |  |   |   |   |   |  |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown  |  |   |   |  |   |   |   |   |  |
|  |  | 24a. Was an autopsy performed?<br>1 □ Yes 2 X No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 □ No   |   |  |   |   |   |   |  |
|  |  | 25. Was case referred to medical examiner?<br>1 X Yes 2 □ No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)<br><b>Hospital 12/07/2010 4:22 P M</b> |   |  |   |   |   |   |  |
|  |  | 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 X Accident 6 □ Could not be determined<br>3 □ Suicide 4 □ Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>12/07/2010</b>  |   | 28b. Time of injury<br><b>4:22 P M</b>   | 28c. Injury at work?<br>1 □ Yes 2 X No                      | 28d. Describe how injury occurred<br><b>Motor Vehicle Accident</b>      |   |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Road</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Big Pool Road @ Clear Spring Road, Clearspring, MD 21740</b>   |   |  |   |   |   |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |   |   |   |  |
|  |  | 29b. Signature and title of certifier<br><b>Shahid Mahmood MD</b>  |  | 29c. License number<br><b>D0063233</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>07/25/2012</b>   |   |   |   |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shahid Mahmood MD 580 C Northern Ave Hagerstown MD 21742</b>  |  |   |   |  |   |   |   |   |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Laura J. Parker</b>   |   |  |   |   |   |   |  |
| Baltimore, Maryland 21215-0036   |  |  |  |   |   |  |   |   |   |   |  |
| Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |  |  |  |   |   |  |   |   |   |   |  |
| Division of Vital Records, P.O. Box 68760  |  |  |  |   |   |  |   |   |   |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.   |  |  |  |   |   |  |   |   |   |   |  |
| To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   |  |  |  |   |   |  |   |   |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner   |  |  |  |   |   |  |   |   |   |   |  |

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and

To the Hospital or Attendi

of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15325

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death<br>5:00 PM   |  |
| BRUCE T. BRYAN   |  | 5 10 2012   |  |   |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |  | 4c. County of Death   |  |
| Tate House   |  | Linthicum   |  | Anne Arundel  |  |
| 5. Social Security Number<br>215-66-9307   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F<br>7. Age (In yrs. last birthday)<br>57 Yrs.   |  | 8. Date of Birth<br>(Month, Day, Year)<br>Dec 17, 1954  |  |
| Usual Residence of Decedent<br>MD  |  | If Under 1 Year<br>Months Days Hours Min.   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |
| 10a. State<br>MD   |  | 10b. County<br>Howard   |  | 10c. City, Town or Location<br>Columbia   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br>9587 Transfer Row  |  | 10f. Zip Code<br>21045  |  | 10g. Citizen of What Country?<br>United States  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. 1972  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>2  |  | 16b. Kind of Business/Industry<br>Chef Restaurant   |  |
| 17. Father's Name (First, Middle, Last)<br>Francis T. Bryan, Sr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pauline T. Creamer   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lynn Fogle / Sister  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6120 West 157 St. Overland Park, KS 66223  |  | Date  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Final Journey Crematory   |  | 20c. Location - City or Town, State<br>5/12/2012 Woodbine, Maryland   |  |
| 21. Signature of Funeral Service Licensee<br>Beverly L. Heckrotte MO1257   |  | 22. Name and Address of Facility<br>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Inset and Death<br>MONTHS  |  |
| a. Due to (or as a consequence of):<br>ESOPHAGEAL CANCER   |  |   |  |   |  |
| b. Due to (or as a consequence of):  |  |   |  |   |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |
| d. _____   |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown         |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) TATE HOUSE |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |  |
|  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>TATE HOUSE   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>R118703  |  | 29d. Date signed (Month, Day, Year)<br>5/11/2012  |  |
| 29b. Signature and title of certifier<br>G-L-Taylor  |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GENEVEIVE L-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, M.D. 21401   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>Laura J. Gandy   |  |   |  |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

12-X-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 30, per DVR, g927 5-15-12 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15326

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |  |   |  |
|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death   |
| <b>WILLIAM J. CHALFONTE</b>   |  | 05 02 2012   |   | 5:13 P.M.  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1231 Penkin Road</b>   |  | 4b. City, Town, or Location of Death<br><b>Pasadena</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |
| 5. Social Security Number<br><b>212-78-4012</b>   |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>53 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>02/09/1959</b> |
| Usual Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |   | 10c. City, Town or Location<br><b>Pasadena</b>   |
| 10e. Street and Number<br><b>1231 Penkin Road</b>   |  | 10f. Zip Code<br><b>21122</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><b>1 □ Never Married 2 X Married</b><br>3 □ Widowed 4 □ Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No</b><br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No</b> Specify:<br><b>White</b> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Field Supervisor</b>                        |   | 16b. Kind of Business/Industry<br><b>Cable Splicing</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>William Chalfont</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Delores Wengert</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Randi Chalfont Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1231 Penkin Road Pasadena, Maryland 21122</b>                                  |   |  |
| 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State</b><br>4 □ Donation 5 □ Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ardent Cremation Inc</b>  | Date<br><b>05/03/2012</b>   | 20c. Location - City or Town, State<br><b>Hanover, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br><b>► Michael P. Marzullo</b>   |  | 22. Name and Address of Facility<br><b>Marzullo Funeral Chapel, P.A.</b><br><b>6009 Harford Road Baltimore, Maryland 21214</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br><b>years</b>   |   |  |
| a. Due to (or as a consequence of):<br><b>MALIGNANCY OF BRAIN</b>   |  |  |   |  |
| b. Due to (or as a consequence of):   |  |  |   |  |
| c. Due to (or as a consequence of):   |  |  |   |  |
| d. Due to (or as a consequence of):   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No 9 □ Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy</b><br><b>4 □ Pregnant at time of death 5 □ Other (specify)</b><br><b>9 □ Unknown</b> |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>   |   |  |
|   |  |  |   | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>  |
|   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b>     |
| 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 X Residence 6 □ Other (Specify)</b>                   |   |  |
| 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation</b><br><b>2 □ Accident 6 □ Could not be determined</b><br><b>3 □ Suicide 7 □ Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |
| 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29b. Signature and title of certifier<br><b>► Eva Hersh</b>   |  | 29c. License number<br><b>D0036581</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/3/12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eva Hersh</b>  |  | 445 Defense Hwy<br>Annapolis, MD 21401   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><b>Suzanne D. Parker</b>  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15327

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

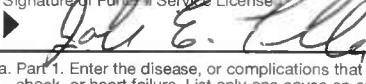
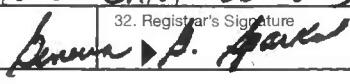
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MAY 14, 2012 12:30 pm

DIANNA CLARK  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dianna Lynn Clark</b>  |  | 2. Date of Death<br>Month <b>May</b> Day <b>14</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>12:30p M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>786 Maple Crest Drive</b>  |  | 4b. City, Town, or Location of Death<br><b>Middle River</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| 5. Social Security Number<br><b>213-70-7432</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><b>54</b> Yrs. | 8. If Under 1 Year<br>Months      Days      Hours      Min.  |
| 9a. Usual Residence of Decedent<br><b>Baltimore</b>   |  | 9b. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 6, 1957</b>   |  | 9c. Birthplace (State or Foreign Country)<br><b>KY</b>   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Essex</b>  |
| 10e. Street and Number<br><b>36 Wiltshire Road</b>  |  | 10f. Zip Code<br><b>21221</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br><b>white</b> |
| 14. Race - American Indian, Black, White, etc.  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>  |
| 16b. Kind of Business/Industry<br><b>Retail</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Frank Smith</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Pisarek</b>   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dianna Jo Clark /daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 Wiltshire Road Baltimore MD 21221</b>   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Bayview Crematory</b>  |  | Date<br><b>5/15/12</b>   |
| 20c. Location - City or Town, State<br><b>Baltimore MD</b>  |  |  |  |  |
| 21. Signature of Funeral Service License<br>   |  | 22. Name and Address of Facility<br><b>300 MACE Ave. Balto. MD</b>   |  | <b>Connelly Funeral Home of Essex 21221</b>  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b>  |  |  |  | Approximate Interval Between Onset and Death   |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):<br><b>LUNG CANCER</b>  |  |  |
|   |  | b. Due to (or as a consequence of):  |  |  |
|   |  | c. Due to (or as a consequence of):  |  |  |
|   |  | d.   |  |  |
| 23c. If female:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23d. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown                  |  | Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><b>Daughter's House</b> |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>R149792</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES CAMP 2300 DULANEY VALLEY RD TIMONIUM MD 21093</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>   |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15328

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|  |             |                             |   |   |      |  |      |                                     |   |  |  |
|--|-------------|-----------------------------|---|---|------|--|------|-------------------------------------|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |             |                             |   | 2. Date of Death  |      |  |      | 3. Time of Death                    |   |  |  |
| <b>DWAYNE CROSWELL</b>   |             |                             |   | Month <b>MAY</b> Day <b>10</b> Year <b>2012</b>   |      |  |      | Time <b>520 PM</b>                  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)   |             |                             |   | 4b. City, Town, or Location of Death  |      |  |      | 4c. County of Death                 |   |  |  |
| <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>   |             |                             |   | <b>BALTIMORE</b>  |      |  |      |                                     |   |  |  |
| 5. Social Security Number  |             | 6. Sex                      | 7. Age (In yrs. last birthday)  | If Under 1 Year   |      | If Under 24 Hrs.   |      | 8. Date of Birth (Month, Day, Year) |   | 9. Birthplace (State or Foreign Country) |  |
| <b>219-78-5930</b>   |             | <b>1 X M 2 □ F</b>          | <b>51</b> Yrs.  | Months  | Days | Hours  | Min. | <b>12 06 60</b>                     | <b>MD</b>   |  |  |
| Usual Residence of Decedent  |             |                             |   |   |      |  |      |                                     |   |  |  |
| 10a. State   | 10b. County | 10c. City, Town or Location |   |   |      |  |      |                                     |   | 10d. Inside City Limits                  |  |
| <b>MD</b>  | <b>NA</b>   | <b>BALTIMORE</b>            |   |   |      |  |      |                                     |   | <b>1 X Yes 2 □ No</b>                    |  |
| 10e. Street and Number   |             |                             |   | 10f. Zip Code   |      |  |      | 10g. Citizen of What Country?       |   |  |  |
| <b>5617 Johnnycake Road</b>  |             |                             |   | <b>21207</b>  |      |  |      | <b>U.S.A.</b>                       |   |  |  |
| 11. Marital Status   |             |                             | 12. Was Decedent Ever in U.S. Armed Forces?   |   |      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |      |                                     | 14. Race - American Indian, Black, White, etc.  |  |  |
| <b>1 X Never Married 2 □ Married</b><br><b>3 □ Widowed 4 □ Divorced</b>  |             |                             | <b>1 □ Yes 2 X No</b><br>If Yes, Give Year or Dates.  |   |      | <b>1 □ Yes 2 X No</b> Specify:   |      |                                     | <b>Specify: Black</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)  |             |                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |   |      | 16b. Kind of Business/Industry   |      |                                     |   |  |  |
| <b>Elementary/Secondary (0-12) 10th grade</b>  |             |                             | <b>College (1-4 or 5+) na</b>   |   |      | <b>Disabled</b>  |      |                                     | <b>Disabled</b>   |  |  |
| 17. Father's Name (First, Middle, Last)  |             |                             |   | 18. Mother's Name (First, Middle, Maiden Surname)   |      |  |      |                                     |   |  |  |
| <b>Floyd Forman</b>  |             |                             |   | <b>Delores Croswell</b>   |      |  |      |                                     |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |             |                             |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |      |  |      |                                     |   |  |  |
| <b>Delores Croswell-Mother</b>   |             |                             |   | <b>3622 Rockdale Ter, Baltimore, Md 21244</b>   |      |  |      |                                     |   |  |  |
| 20a. Method of Disposition   |             |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   |      | Date   |      | 20c. Location - City or Town, State |   |  |  |
| <b>1 □ Burial 2 □ Cremation 3 □ Removal from State</b><br><b>4 □ Donation 5 □ Other (Specify)</b>  |             |                             | <b>Druid Ridge</b>  |   |      | <b>5/19/2012</b>   |      | <b>Pikesville, Md</b>               |   |  |  |
| 21. Signature of Funeral Service Licensee  |             |                             | 22. Name and Address of Facility  |   |      |  |      |                                     |   |  |  |
| <b>Donald C. Stump</b>   |             |                             | <b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, md 21215</b>  |   |      |  |      |                                     |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |                             |   |   |      |  |      |                                     | Approximate Interval Between Onset and Death  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |             |                             |   |   |      |  |      |                                     |   |  |  |
| a. <b>Septicemia w/disseminated intravascular coagulation</b><br>Due to (or as a consequence of):  |             |                             |   |   |      |  |      |                                     |   |  |  |
| b. _____<br>Due to (or as a consequence of):   |             |                             |   |   |      |  |      |                                     |   |  |  |
| c. _____<br>Due to (or as a consequence of):   |             |                             |   |   |      |  |      |                                     |   |  |  |
| d. _____   |             |                             |   |   |      |  |      |                                     |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No 9 □ Unknown  |             |                             | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (Specify)<br>9 □ Unknown |   |      | 23d. Date of delivery<br>Month Day Year  |      |                                     |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Liver cirrhosis 2/2 Hepatitis C</b><br><b>Hypopharyngeal squamous cell carcinoma</b>  |             |                             |   |   |      |  |      |                                     | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 □ No 3 X Probably 4 □ Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   |             |                             | 26. Place of Death (Check only one)<br>Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA<br>Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)         |   |      | 23f. Was an autopsy performed?<br>1 □ Yes 2 X No   |      |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 □ No     |  |  |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined<br>3 □ Suicide<br>4 □ Homicide  |             |                             | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 □ Yes 2 □ No  |   |      | 28d. Describe how injury occurred  |      |                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                      |  |  |
| 29a. Certifier<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             |                             | 29b. Signature and title of certifier<br><b>Brittney Williams MD</b>  |   |      | 29c. License number<br><b>1811892240</b>   |      |                                     | 29d. Date signed (Month, Day, Year)<br><b>05/10/2012</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brittney Williams 22 South Greene St. Baltimore, MD 21201</b>   |             |                             |   |   |      |  |      |                                     |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |             |                             | 32. Registered by _____   |   |      |  |      |                                     |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15329

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |
|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ammy Jeannette Chavez</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>10:30 A.M.</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Saint Joseph Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |
| 5. Social Security Number<br><b>218-92-6516</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>53</b> Yrs. | If Under 1 Year<br>Months    Days    Hours    Min.   |
| 8. Usual Residence of Decedent<br><b>Maryland Baltimore County</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Nicaragua, Central America</b>   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore County</b>  |  | 10c. City, Town or Location<br><b>Towson</b>   |
| 10e. Street and Number<br><b>1513 Jeffers Road</b>   |  | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 04</b>   |  | 16b. Kind of Business/Industry<br><b>Loan Officer Banking</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Julio Chavez</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esperanza Transito</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Connie E. Shiner (Friend)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1513 Jeffers Road Towson, Maryland 21204</b>  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of Cemetery, Cemetery or other place)<br><b>Dulaney Valley Memorial Gardens</b>   |  | 20c. Date of Disposition<br><b>Tuesday May 15, 2012</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair, Sr. CFSP</b><br><b>Lic. #M00677</b>   |  | 22. Name and Address of Facility<br><b>Reverent Alternatives Funeral and Cremation Center, P.A.</b><br><b>235 York Road Timonium, Maryland 21093-2215</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>6 Months</b>   |  |  |
| a. <b>End Stage Liver Disease</b><br>Due to (or as a consequence of):<br><b>Severe Sepsis</b><br>b. Due to (or as a consequence of):<br><b>Acute Renal Failure</b><br>c. Due to (or as a consequence of):<br><b>d.</b>   |  | <b>11 Days</b>  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>   | 28b. Time of injury<br><b>M</b>                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. J. Gair</b>  |  | 29c. License number<br><b>D65045</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/13/12</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Preetam Jolepalam M.D. 7601 Osler Drive Towson Maryland 21204</b>   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Jeanne D. Gair</b>  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15330

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)

**Wayne Steven Cockey**

2. Date of Death

Month **MAY** Day **11**, Year **2012**

3. Time of Death

**11:08 AM**

4a. Facility Name (if not institution, give street and number)

**SAINT JOSEPH MEDICAL CENTER**

4b. City, Town, or Location of Death

**TOWSON**

4c. County of Death

**BALTIMORE**

5. Social Security Number

**220-54-7618**

6. Sex

M

F

7. Age (in yrs. last birthday)

**62** Yrs.

If Under 1 Year:

Months

If Under 24 Hrs:

Days

8. Date of Birth

(Month, Day, Year)

**March 22, 1950**

9. Birthplace (State or Foreign Country)

**Baltimore, MD.**

Usual Residence of Decedent

10a. State **Maryland**

10b. County **Baltimore County**

10c. City, Town or Location **Pikesville**

10d. Inside City Limits

Yes  No

10e. Street and Number

**609 Cyburn Road**

10f. Zip Code

**21208**

10g. Citizen of What Country?

**United States**

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) **12** College (1-4 or 5+) **N/A**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**Machine Mechanic**

16b. Kind of Business/Industry

**Sweetheart Cup Corp.**

17. Father's Name (First, Middle, Last)

**James Edward Cockey**

18. Mother's Name (First, Middle, Maiden Surname)

**Joan Loretta Payne**

19a. Informant's Name/Relationship (Type, Print)

**Mrs. Cindy A. Trainor (sister)**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**56 Far Corners Loop Sparks, Maryland 21152**

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, cemetery or other place)

**Dulaney Valley Memorial Gardens**

Date

**Monday May 14, 2012**

20c. Location - City or Town, State  
**(Baltimore County) Timonium, Maryland**

21. Signature of Funeral Service Licensee

**Jeffrey L. Gair, Sr. OFS**

Lic. #M00677

22. Name and Address of Facility

**Peaceful Alternatives Funeral and Cremation Center, P.A.**

2325 York Road Timonium, Maryland 21093-2215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

**LEG INFARCTION DUE TO OBSTRUCTED GRAFT**

Approximate Interval Between Onset and Death

**3 DAYS**

a. Due to (or as a consequence of):

**ACUTE MYOCARDIAL INFARCTION**

**3 DAYS**

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery

Month **Day** **Year**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**PULMONARY EDEMA**

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

**SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

**ACUTE RENAL FAILURE**

24a. Was an autopsy performed?

Yes  No

24b. Were autopsy findings available prior to completion of cause of death?

Yes  No

25. Was case referred to medical examiner?

Yes  No

Hospital:  Inpatient  ER/Outpatient  DOA

Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural  
 Accident  
 Suicide  
 Homicide

Pending Investigation  
 Could not be determined

28a. Date of injury (Month, Day, Year)

**M**

28b. Time of injury

**M**

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician

Medical Examiner

Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

**Linda Barr, M.D.**

29c. License number

**D35453**

29d. Date signed (Month, Day, Year)

**5/11/12**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**LINDA BARR, M.D. 7601 OSLER DRIVE, TOWSON, MD 21204**

31. Date filed (Month, Day, Year)

**MAY 15 2012**

32. Registrar's Signature

**Linda Barr**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15331

1- For  
State  
Registrar

|                                     |   |   |   |  |  |  |   |                                    |
|-------------------------------------|---|---|---|--|--|--|---|------------------------------------|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Richard H. Cherry</b>  |   |   |  |  |  | 2. Date of Death<br>Month <b>S</b> Day <b>10</b> Year <b>2012</b>       | 3. Time of Death<br><b>1051 AM</b> |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>VA Maryland Healthcare System</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Perry Point</b>   |  |  | 4c. County of Death<br><b>Cecil</b>                                     |                                    |
| Funeral<br>Director                 | 5. Social Security Number<br><b>223-76-6113</b>   | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>59 Yrs.</b>  | If Under 1 Year<br>Months<br><b>12</b>   | If Under 24 Hrs.<br>Days<br><b>9</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>12-9-1952</b> | 9. Birthplace (State or Foreign Country)<br><b>Suffolk, VA</b>          |                                    |
| To Be Completed by Funeral Director | Usual Residence of Decedent<br>10a. State <b>Md.</b> 10b. County <b>P.G.</b> 10c. City, Town or Location <b>Oxon Hill</b>   |   |   |  |  |  | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>                        |                                    |
|                                     | 10e. Street and Number<br><b>7500 Abbington Drive</b>   |   |   | 10f. Zip Code<br><b>20745</b>  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |                                    |
|                                     | 11. Marital Status<br><b>1 X Never Married 2 □ Married<br/>3 □ Widowed 4 □ Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No<br/>If Yes, Give Year or Dates.<br/><b>1972-1974</b></b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b>                        |  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b> |                                    |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Disabled</b>                       |  |  | 16b. Kind of Business Industry<br><b>Disabled</b>                       |                                    |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hazel Cherry</b>   |  |   |                                    |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charita Howell - Niece</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>303 Spruce Street, Suffolk, Virginia 23434</b> |  |   |                                    |
| Physician/<br>Medical<br>Examiner   | 20a. Method of Disposition<br><b>1 □ Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Albert Horton Vet Cem</b>   |  | Date<br><b>5-18-12</b>                                     | 20c. Location - City or Town, State<br><b>Suffolk, VA</b>               |                                    |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Ronald Taylor II FH</b>   |   |   | 22. Name and Address of Facility<br><b>10583 Middleport Ln. White Plains, MD 20695</b>   |  |  |   |                                    |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>An myelothrophic lateral sclerosis.</b><br>Approximate Interval Between Onset and Death<br><b>3 yrs</b>  |   |   |  |  |  |   |                                    |
|                                     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |   |   |  |  |  |   |                                    |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 X No<br/>9 □ Unknown</b>  |   |   | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (specify)<br/>9 □ Unknown</b> |  |  | 23d. Date of delivery<br>Month Day Year                                 |                                    |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Respiratory Failure.</b>   |   |   |  |  |  |   |                                    |
|                                     | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>  |   |   |  |  |  |   |                                    |
|                                     | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 X No</b>   |  |   |                                    |
|                                     | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>   |   | 26. Place of Death (Check only one)<br><b>Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b> |  |  |  |   |                                    |
|                                     | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide<br/>4 □ Homicide</b>   |   | 28a. Date of injury (Month, Day, Year)<br><b>15</b>   | 28b. Time of injury<br><b>M</b>  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>  | 28d. Describe how injury occurred                          |   |                                    |
|                                     |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Perry Point, MD 21902</b>                                       |  |   |                                    |
|                                     | 29a. Certifier<br>(Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   | 29b. Signature and title of certifier<br><b>S. Soch</b>   |  |  |  |   |                                    |
|                                     |   |   | 29c. License number<br><b>D42014</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/12</b>      |   |                                    |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Surinderpal S. Soch, MD, VA Maryland Health Care System, Perry Point, MD 21902</b>   |   |   |  |  |  |   |                                    |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   | 32. Registrar's Signature<br><b>S. Soch</b>   |  |  |  |   |                                    |

Name Known to Physician: Cherry, Richard H.  
Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2012 15332

|  |  |  |                                |   |  |   |   |   |  |  |  |  |  |
|--|--|--|--------------------------------|---|--|---|---|---|--|--|--|--|--|
| Physician/<br>Medical Examiner                                       |  | 1. For State<br>Registrar  |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | 1. Decedent's Name (First, Middle, Last)   |                                |   |  |   | 2. Date of Death                                    |   |  | Reg. No.   |  |  |  |
|  |  | Jean-Frederic Cottrille  |                                |   |  |   | Month Day Year                                      |   |  | 0727 hrs   |  |  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br>8914 Tonbridge Terrace   |                                |   |  |   | 4b. City, Town, or Location of Death<br>Hyattsville |   |  | 4c. County of Death<br>Prince George's   |  |  |  |
| Funeral<br>Director  |  | 5. Social Security Number<br>230-84-5645   |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>49 Yrs.   |   | If Under 1 Year<br>Months Days Hours Min.   |  | 8. Date of Birth (MM/DD/YYYY)<br>02/14/1963  |  |  |  |
|  |  |  |                                |   |  |   |   |   |  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  |  |  |
| To Be Completed by Funeral Director                                  |  | Usual Residence of Decedent  |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | 10a. State<br>MD   | 10b. County<br>Prince George's |   | 10c. City, Town or Location<br>Hyattsville |   |   |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  |  | 10e. Street and Number<br>8914 Tonbridge Terrace   |                                |   |  | 10f. Zip Code<br>20788  |   |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| To Be Completed by Physician/Medical Examiner                        |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Electrician  |  | 16b. Kind of Business/Industry<br>Construction  |   |   |  |  |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br>Frederick Dale Cottrille  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Janice Lee Wells   |  |   |   |   |  |  |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Jean-Luc Cottrille / Son   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4305 Nantucket Dr. NW, Wilson, NC 27896  |  |   |   |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br>Robby  |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Anatomy Gifts Registry  |  | Date<br>05/15/2012  |   | 20c. Location - City or Town, State<br>Hanover, Maryland  |  |  |  |  |  |
|  |  | 21. Signature of Funeral Service Licensee  |                                | 22. Name and Address of Facility<br>Anatomy Gifts Registry  |  | 7522 Connelley Dr., Ste. P, Hanover, MD 21076   |   |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):   |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | b. _____<br>Due to (or as a consequence of):   |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | c. _____<br>Due to (or as a consequence of):   |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | d. _____   |                                |   |  |   |   |   |  |  |  |  |  |
|  |  | <input checked="" type="checkbox"/> UNPENDED   |                                | <input type="checkbox"/> AMENDED 23a, 27, per me, g927 5-18-12 sm   |  |   |   |   |  |  |  |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |                                | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>g <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |   |   |  |  |  |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |   |  |  |  |  |  |
|  |  |  |                                |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
|  |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |  | 26. Place of Death (Check only one)<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene                              |   |   |  |  |  |  |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |                                | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred  |  |  |  |
|  |  |  |                                |   |  |   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
|  |  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                |   |  |   |   | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>May 7, 2012   |  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a)<br>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223   |                                |   |  |   |   |   |  |  |  |  |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |                                | 32. Registrar's Signature<br>Linda A. Southall  |  |   |   |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15333

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

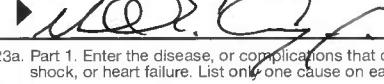
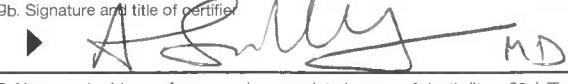
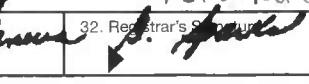
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State  
Registrar

|  |  |   |   |   |  |  |  |   |                              |
|--|--|---|---|---|--|--|--|---|------------------------------|
| 1. Decedent's Name (First, Middle, Last)   |  | Clarence Richard Cavey  |   |   |  | 2. Date of Death<br>Month<br>May   | Day<br>12,   | Year<br>2012  | 3. Time of Death<br>23:42 PM |
| 4a. Facility Name (if not institution, give street and number)   |  | Pasadena  |   |   |  | 4c. County of Death<br>Anne Arundel Co.  |  |   |                              |
| 8024 Pine Ridge Road   |  |   |   |   |  |  |  |   |                              |
| 5. Social Security Number<br>214-40-0494   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>69 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br>06/30/1942   | 9. Birthplace (State or Foreign Country)<br>Maryland             |   |                              |
| Usual Residence of Decedent<br>MD  |  | 10c. City, Town or Location<br>Pasadena   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                              |
| 10a. State<br>MD   |  | 10b. County<br>Anne Arundel Co.   |   | 10f. Zip Code<br>21122  |  |  |  | 10g. Citizen of What Country?<br>United States  |                              |
| 10e. Street and Number<br>8024 Pine Ridge  |  |   |   |   |  |  |  |   |                              |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |                              |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)   |   | Computer Technician   |  |  | 16b. Kind of Business/Industry<br>Newspaper                      |   |                              |
| 17. Father's Name (First, Middle, Last)<br>Clifton M. Cavey  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mildred D. Lambdin   |   |   |  |  |  |   |                              |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Cynthia C. Cavey / Wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8024 Pine Ridge Road Pasadena, MD 21122  |   |   |  |  |  |   |                              |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Mem. Park   |   | Date<br>5/17/2012   | 20c. Location - City or Town, State<br>Elkridge, Maryland                            |  |  |   |                              |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061  |   |   |  |  |  |   |                              |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Lung Cancer   |   |   |  | Approximate Interval Between Onset and Death   |  |   |                              |
| Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):   | b. Due to (or as a consequence of):       | c. Due to (or as a consequence of):   | d. Due to (or as a consequence of):  |  |  |   |                              |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>g <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |   |                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Lung Disease   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |                              |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |   | Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                              |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                              |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |   |                              |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>DSO470   |   |   |  | 29d. Date signed (Month, Day, Year)<br>5/14/12   |  |   |                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SRIDHAR ATLUARI 7310 Ritchie Highway #800; Glen Burnie MD 21061  |  |   |   |   |  |  |  |   |                              |
| 31. Date file (Month, Day, Year)<br>MAY 15 2012  |  | 32. Registrar's Signature<br>  |   |   |  |  |  |   |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15334

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

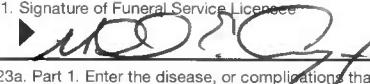
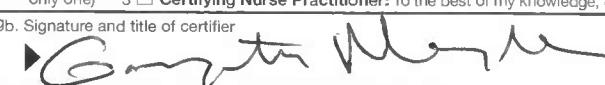
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |   |                                |  |  |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  |                                | 3. Time of Death   |  |
| Pauline Laverne Calderone   |  | Month<br>05   | Day<br>11                      | Year<br>2012   | 08:08 A M  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                                | 4c. County of Death  |  |
| 1198 Holmespun Drive  |  | Pasadena  |                                | Anne Arundel   |  |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.  |
| 223-60-7768   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 66 Yrs.                        |  |  |
| Usual Residence of Decedent   |  | 8. Date of Birth (Month, Day, Year)   |                                |  |  |
|   |  | 06/16/1945  |                                |  |  |
| 9. Birthplace (State or Foreign Country)  |  | 10d. Inside City Limits   |                                |  |  |
| Texas   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                |  |  |
| 10a. State  |  | 10b. County   |                                | 10c. City, Town or Location  |  |
| MD  |  | Anne Arundel Co.  |                                | Pasadena   |  |
| 10e. Street and Number  |  | 10f. Zip Code   |                                | 10g. Citizen of What Country?  |  |
| 1198 Holmespun Drive  |  | 21122   |                                | United States  |  |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                | 16b. Kind of Business/Industry   |  |
| Elementary/Secondary (0-12)<br>12   |  | College (1-4 or 5+)   |                                | Dental Assistant Health Care   |  |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |  |  |
| Walter Slade  |  | Sadie Pereths   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |  |
| Mr. David W. Calderone / Son  |  | 1198 Holmespun Drive Pasadena, MD 21122   |                                |  |  |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date   | 20c. Location - City or Town, State  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment  |  | Cedar Hill Cemetery   |                                | 05/17/2012   | Brooklyn Park, MD  |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |  |  |
|    |  | Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061  |                                |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death  |                                |  |  |
| Metastatic Non small cell lung cancer   |  |   |                                |  |  |
| {<br>a. Due to (or as a consequence of):<br>Brain metastasis  |  |   |                                |  |  |
| b. Due to (or as a consequence of):<br>Growth   |  |   |                                |  |  |
| c. Due to (or as a consequence of):   |  |   |                                |  |  |
| d. Due to (or as a consequence of):   |  |   |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                 |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Residence |                                |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |                                | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br>29c. License number<br>D39041   |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  | 29d. Date signed (Month, Day, Year)<br>May 17th 2012  |                                |  |  |
| AYATRI NURSING ASSISTANT<br>305 Glen Hospital Drive 21061   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature<br>  |                                |  |  |
| MAY 15 2012   |  |   |                                |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

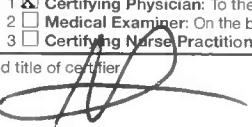
**Certificate of Death**

Reg. No.

2012 15335

**1 -** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|--|--|---|--|---|--|---------------------------|---|-------|--|---|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Helga Else Berta Castro</b>  |  |   |  |                           |   |       | 2. Date of Death<br>Month <b>May</b> Day <b>12</b> , Year <b>2012</b>  | 3. Time of Death<br><b>6:15 AM</b>  |  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>9128 Orchard Brook Drive</b>   |  |   |  |                           |   |       | 4b. City, Town, or Location of Death<br><b>Potomac</b>   | 4c. County of Death<br><b>Montgomery</b>  |  |  |
|  |  | 5. Social Security Number<br><b>100-38-4184</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | Hours | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 13, 1937</b>  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                     |  |
|  |  | Usual Residence of Decedent   |  | 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Potomac</b>   |  |                           |   |       |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  |  | 10e. Street and Number<br><b>9128 Orchard Brook Drive</b>   |  |   |  |                           | 10f. Zip Code<br><b>20854</b>   |       |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>   |  |   |  |                           | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Physician</b>  |       |  | 16b. Kind of Business/Industry<br><b>Medicine</b>   |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Helmut Paul Herbert Finke</b>   |  |   |  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hildegarde Elisabeth Margarete Jennrich</b>   |       |  |   |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dr. Oswaldo Castro/Husband</b>   |  |   |  |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9128 Orchard Brook Drive, Potomac, Maryland 20854</b>   |       |  |   |  |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>A11 Souls Cemetery</b>   |       |  | Date<br><b>May 18, 2012</b>   | 20c. Location - City or Town, State<br><b>Germantown, Maryland</b>                             |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  |  |   |  |                           | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br/>300 West Montgomery Ave., Rockville, Maryland 20850</b>  |       |  |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   |  |                           | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |       |  | Approximate Interval Between Onset and Death<br><b>Chronic</b>  |  |  |
|  |  | <p>a. Due to (or as a consequence of):<br/><b>Carcinoid</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |  |   |  |                           |   |       |  |   |  |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                           |   |       | 23d. Date of delivery<br>Month Day Year  |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |                           |   |       | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA  |  |                           | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |       |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |       | 28d. Describe how injury occurred  |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input type="checkbox"/> Certifying Nurse Practitioner   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |  |                           |   |       |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 29b. Signature and title of certifier<br>  |  |   |  |                           | 29c. License number<br><b>D62234</b>  |       |  | 29d. Date signed (Month, Day, Year)<br><b>May 14, 2012</b>  |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Manish Agrawal, M.D. 9707 Medical Center Drive #300, Rockville, Maryland 20850</b>   |  |   |  |                           |   |       |  |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br>  |  |                           |   |       |  |   |  |  |
|  |  |   |  |   |  |                           |   |       |  |   |  |  |

**Baltimore, Maryland 21215-0036**

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

**State  
Registrar**

**30J**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

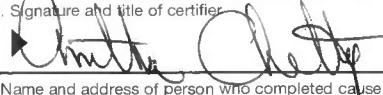
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15336

Reg. No.

1 - For  
State  
Registrar

|   |  |   |   |   |   |  |  |  |
|---|--|---|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Grace May Chu</b>   |   |   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> , Year <b>2012</b>   | 3. Time of Death<br>4:50 AM  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Suburban Hospital</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |   |  | 4c. County of Death<br><b>Montgomery</b>                               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>226-13-3735</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>49</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 22, 1962</b> | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>            |  |
|   | 10a. State<br><b>Maryland</b>  |   |   | 10b. County<br><b>Montgomery</b>  |   |  | 10c. City, Town or Location<br><b>Germantown</b>                       |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>11521 Brundidge Terrace</b>   |   |   |   | 10f. Zip Code<br><b>20876</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | College (1-4 or 5+)<br><b>5+</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Operations Manager</b> |   |  | 16b. Kind of Business/Industry<br><b>National Institutes of Health</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>Shou-Chang Chu</b>  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Judith K. Chow</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Albert P. Chu/Brother</b>  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>37 Crenshaw Drive, Flanders, New Jersey 07836</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>                                       |   |   | Date<br><b>May 11, 2012</b>                                    | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>       |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Chase, Inc.</b><br><b>7557 Wisconsin Ave., Bethesda, Maryland 20814-3501</b> |   |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |   |   |   |  |  |  |
| a. Due to (or as a consequence of):<br><b>Metastatic Breast Cancer</b>  |  |   |   |   |   |  |  |  |
| b. Due to (or as a consequence of):<br><b>Hypoxic Respiratory Failure</b>   |  |   |   |   |   |  |  |  |
| c. Due to (or as a consequence of):   |  |   |   |   |   |  |  |  |
| d. Due to (or as a consequence of):   |  |   |   |   |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   |   |  |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |  |   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   |  |   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                              |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>70267</b>   |   |   |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/7/2012</b>   |
| 29b. Signature and title of certifier<br>  |  |   |   |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anitha Chetty, M.D.</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   |   |   |  |  | 32. Registrar's Signature<br>   |

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

0450A.M.

CH49452  
05/06/2012  
Division of Vital Records, P.O. Box 68760

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

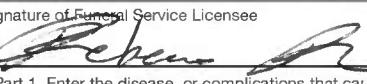
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15337

1 - For  
State  
Registrar

|   |  |   |   |   |  |   |  |                                   |
|---|--|---|---|---|--|---|--|-----------------------------------|
| Physician/<br>Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Evelyn Jane Conroy</b>  |   |   |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>11</b> Year <b>2012</b>     | 3. Time of Death<br><b>0940AM</b>  |                                   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>GENESIS CATON MANOR</b>   |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                |  | 4c. County of Death<br><b>N/A</b> |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-01-3523</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>107</b><br>Yrs.  | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 7, 1905</b>          | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                   |
| To Be Completed by Funeral Director           | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |
|   | 10e. Street and Number<br><b>4023 Colchester Rd. Apt. 217</b>  |   |   | 10f. Zip Code<br><b>21229</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |                                   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b>   |   |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>                     |  |                                   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Jack Bates</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Mundler</b>  |  |   |  |                                   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jack Mellema, nephew</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3704 MacTavish Ave. Baltimore, MD. 21229</b>  |  |   |  |                                   |
| Physician/<br>Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial</b>  |   | Date <b>05-15-2012</b>   | 20c. Location - City or Town, State<br><b>Towson, MD</b>                |  |                                   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Ambrose Funeral Home, Inc.</b><br><b>1328 Sulphur Spring Rd. Arbutus, MD. 21227</b>  |   |  |   |  |                                   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Due to (or as a consequence of):<br><b>chronic Kidney Disease</b><br>Approximate Interval Between Onset and Death<br><b>4 YEARS</b>   |   |   |   |  |   |  |                                   |
|   | b. Due to (or as a consequence of):  |   |   |   |  |   |  |                                   |
|   | c. Due to (or as a consequence of):  |   |   |   |  |   |  |                                   |
|   | d. Due to (or as a consequence of):  |   |   |   |  |   |  |                                   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month      Day      Year                       |  |                                   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Hyperlipidemia</b><br><b>Hypertension</b>   |   |   |   |  |   |  |                                   |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |   |  |                                   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |   |  |                                   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |                                   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |                                   |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |                                   |
|   | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |                                   |
|   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>R133381</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 11, 2012</b>              |  |                                   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CAROL D WATKINS NP</b>  |   | 3330 WILKENS AVE, BALTO MD 21229  |   |  |   |  |                                   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   | 32. Registrar's Signature<br>  |   |  |   |  |                                   |

CONROY  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15338

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

|  |                          |   |   |  |  |  |  |  |  |  |
|--|--------------------------|---|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |                          | 2. Date of Death<br>Month Day Year  |   |  |  | 3. Time of Death                                     |  |  |  |  |
| Ruth Z. Copper   |                          | May 8, 2012   |   |  |  | 6:05 p.m.  |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>7748 Wynbrook Road   |                          | 4b. City, Town, or Location of Death<br>Baltimore   |   |  |  | 4c. County of Death<br>Baltimore                     |  |  |  |  |
| 5. Social Security Number<br>212-34-6715   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>76 Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br>02/19/1936 | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |  |
| Usual Residence of Decedent  |                          |   |   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10a. State<br>MD   | 10b. County<br>Baltimore | 10c. City, Town or Location<br>Baltimore  |   |  |  |  |  |  |  |  |
| 10e. Street and Number<br>7748 Wynbrook Road   |                          | 10f. Zip Code<br>21224  |   |  |  | 10g. Citizen of What Country?<br>U.S.A.              |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                               |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |                          | 16a. Decedent's Usual Occupation<br>(Kind of work done during most of working life. DO NOT use retired)<br>Clerk  |   | 16b. Kind of Business/Industry<br>Automotive   |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Bernard Donnelly  |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>Medora Snyder  |   |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Erin Mackey/Daughter   |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2470 Christine Court, Kingsley, MI 49649   |   |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus 5/15/12 Baltimore, MD   |   | Date   | 20c. Location - City or Town, State<br>Lilly's Funeral Home<br>1901 Eastern Ave, Baltimore, MD 21231 |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |                          | 22. Name and Address of Facility<br>Lilly's Funeral Home<br>1901 Eastern Ave, Baltimore, MD 21231   |   |  |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                          | 23b. Due to (or as a consequence of):<br><br>a. END STAGE DEMENTIA<br>b. _____<br>c. _____<br>d. _____  |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |  |
| Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                          |   |   |  |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                          | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____                               |   |  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                          |   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |                          | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                     | 28d. Describe how injury occurred                    |  |  |  |  |
|  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                          |   |   |  |  |  |  | 29c. License number<br>B14992  | 29d. Date signed (Month, Day, Year)<br>5/11/2012 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JACKIE JONES CRNP 2300 DULANEY VALLEY RD TIMONIUM, MD 21093  |                          |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |                          | 32. Registrar's Signature<br>  |   |  |  |  |  |  |  |  |

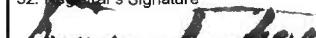
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### **Certificate of Death**

Reg. No.

2012 | 5339

|                                |  |  |  |   |   |  |  |   |  |  |  |  |  |
|--------------------------------|--|--|--|---|---|--|--|---|--|--|--|--|--|
| Physician/<br>Medical Examiner |  | 1. Decedent's Name (First, Middle, Last)<br><b>Anthony Lopez Dickey</b>  |  |   |   |  |  | 2. Date of Death<br>Month Day Year<br>May 7, 2012   | 3. Time of Death<br>2200 hrs   |  |  |  |  |
| Funeral<br>Director            |  | 4a. Facility Name (if not institution, give street and number)<br><b>6810 Haven Avenue</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Oxon Hill</b>  |  |  | 4c. County of Death<br><b>Prince George's</b>       |  |  |  |  |  |
|                                |  | 5. Social Security Number<br><b>579-80-3581</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>49</b>   | Yrs.   | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth (MM/DD/YYYY)<br><b>Feb 28 1963</b> | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>           |  |  |  |  |
|                                |  | Usual Residence of Decedent:<br>10a. State<br><b>MD</b> 10b. County<br><b>Prince George's</b> 10c. City, Town or Location<br><b>Oxon Hill</b> 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |   |  |  |  |  |  |
|                                |  | 10e. Street and Number<br><b>6810 Haven Avenue</b>   |  |   | 10f. Zip Code<br><b>20745</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>         |  |  |  |  |  |
|                                |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b><br>Specify: |  |  |  |  |
|                                |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2yrs.</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Consultant</b>                        |  |  | 16b. Kind of Business/Industry<br><b>Government</b> |  |  |  |  |  |
|                                |  | 17. Father's Name (First, Middle, Last)<br><b>Howard Dickey</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia Gause</b>   |  |   |  |  |  |  |  |
|                                |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Dickey / Mother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6810 Haven Avenue, Oxon Hill, Maryland, 20745</b> |  |  |   |  |  |  |  |  |
|                                |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: <b>Ft. Lincoln Cemetery</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  |  | Date<br><b>05/15/2012</b>                           | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>          |  |  |  |  |
|                                |  | 21. Signature of Funeral Service Licensee<br><b>Daphney N. Cornelius</b>   |  |   | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, Maryland 20785</b>                                 |  |  |   |  |  |  |  |  |
| Physician/<br>Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Seizure Disorder</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |  |   |   |  |  |   |  |  |  |  |  |
|                                |  | <input type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED  |   |  |  |   |  |  |  |  |  |
|                                |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |  |  |
|                                |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |  |  |  |  |
|                                |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |   |  |  |  |  |  |
|                                |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |   |  |  |   |  |  |  |  |  |
|                                |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                   |  |  |  |  |  |
|                                |  |  |  |   |   |  |  |   |  |  |  |  |  |
|                                |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
|                                |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                              |  |   |   |  |  |   |  |  |  |  |  |
|                                |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b>  |  |   |  |  |  |  |  |
|                                |  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |   |  |  |   |  |  |  |  |  |
| State<br>Registrar             |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |  |  |  |

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, none of it should be detached for use at the burial or transit.

## **Medical Certification: To Be Completed by Physician/Medical Examiner**

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 23a-f show any or other unusual event the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
 AMEND ITEM#20b, per FH, G927, 5/22/2012, WS  
 State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

**Certificate of Death**

Reg. No. 2012 15340

**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |   |   |   |
|---|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month 5 Day 9 Year 2012   |   | 3. Time of Death<br>M 0749 M  |
| CHARLES S DIGIORGIO   |  |   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><br>UMMC  |  | 4b. City, Town, or Location of Death<br><br>BALTIMORE   |   | 4c. County of Death   |
| 5. Social Security Number<br><br>116-28-8833  |  | 6. Sex<br><br>X M 2 F   | 7. Age (In yrs. last birthday)<br><br>74 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>07 10 37  |
| 9. Birthplace (State or Foreign Country)<br><br>NY  |  |   |   |   |
| 10a. State<br><br>NY  |  | 10b. County<br><br>Herkimer   |   | 10c. City, Town or Location<br><br>Frankfort  |
| 10d. Inside City Limits<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |
| 10e. Street and Number<br><br>156 Carder Lane   |  | 10f. Zip Code<br><br>13340  |   | 10g. Citizen of What Country?<br><br>U.S.A.   |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><br>14. Race - American Indian, Black, White, etc.<br><br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) 12th grade  |  | 16a. Decedent's Usual Occupation<br>(Give name of work done during most of working life. DO NOT use retired)<br><br>College (1-4 or 5+) na Mechanic   |   | 16b. Kind of Business/Industry<br><br>Automotive  |
| 17. Father's Name (First, Middle, Last)<br><br>Giacindo DiGiorgio   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><br>Teresa E. Coriale  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><br>Margaret DiGiorgio-Wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br>156 Carder Lane, Frankfort, New York 13340   |   |   |
| 20a. Method of Disposition<br><br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br>Calvary   |   | Date <input type="checkbox"/> Unknown 20c. Location - City or Town, State<br><br>5/23/2012 Herkimer, New York   |
| 21. Signature of Funeral Service Licensee<br><br>Lala March   |  | 22. Name and Address of Facility<br><br>March F/H West 4300 Wabash Ave, Baltimore, Md 21215   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br><br>Sepsis 10   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |   |
| a. Due to (or as a consequence of):<br><br>Pulmonary Contusions 10  |  |   |   |   |
| b. Due to (or as a consequence of):<br><br>Traumatic Brain Injury 10  |  |   |   |   |
| c. Due to (or as a consequence of):<br><br>d. _____   |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DIABETES MELLITUS   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |
| HYPERTENSION  |  |   |   |   |
| CHRONIC KIDNEY DISEASE  |  |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)            |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br>4/27/2012  | 28b. Time of injury<br>1900 PM                | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   |  | 28d. Describe how injury occurred<br>NVC  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway   |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>NBI 81 3 mile marker 25 Martin'sburg, WV  |   |   |
| 29b. Signature and title of certifier<br><br>Dawn Powell, MD  |  | 29c. License number<br>NE 24489   |   | 29d. Date signed (Month, Day, Year)<br>5/10/2012  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dawn Powell, MD Walter Reed Natl. Med Cen, Bethesda, MD 20889   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012  |  | 32. Registrar's Signature<br>Anne A. Farrel   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012

1534

For  
State  
Registrar

|  |  |  |  |  |   |  |   |  |  |
|--|--|--|--|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD LEE DARROUGH, SR.</b>  |  |  |  |   | 2. Date of Death<br>Month<br><b>May</b> Day<br><b>14</b> , Year<br><b>2012</b>   | 3. Time of Death<br>Hour<br>Min.<br><b>4:30 A M</b>               |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>426 Old Trail</b>   |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   | 4c. County of Death<br><b>Baltimore County</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>305-42-3129</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months<br><input type="checkbox"/> | If Under 24 Hrs.<br>Hours<br><input type="checkbox"/>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug 18, 1935</b>     | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>                                     |  |
|  | Usual Residence of Decedent<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore County</b>   | 10c. City, Town or Location<br><b>Baltimore</b>       |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>426 Old Trail</b>   |  |  | 10f. Zip Code<br><b>21212</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces? <b>'54-'58</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>12</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>                       |   | 16b. Kind of Business/Industry<br><b>Installation Technician</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Rayburn Thomas Darrough</b>  |  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Esther Olman</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn A. Darrough (Wife)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>426 Old Trail, Baltimore, Maryland 21212</b>                 |   |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>   |   | Date<br><b>5/15/2012</b>   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Martin D. Lawson</b>   |  |  | 22. Name and Address of Facility<br><b>MITCHELL-WIEDEFELD FUNERAL HOME, INC.<br/>6500 York Road, Baltimore, Maryland 21212</b>                                   |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung cancer</b>   |  |  |  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b>  |  |  |  |   |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b>  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury<br/>M</b> 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Cynthia Soriano</b>  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>DOO51347</b>   |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>5/15/2012</b>  |  |  |  |   |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cynthia Soriano, M.D., 6535 N Charles St., North Pavillion Suite 550, Towson, MD</b>  |  |  |  |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Jessica S. Parker</b>                      |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items 28b,f per me, g927-05/11/2012dhb Certificate of Death

Reg. No.

2012 15342

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Gordon Dring  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

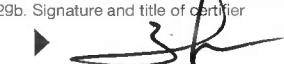
Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |  |   |                                |   |   |   |  |  |
|--|--|---|--------------------------------|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |                                |   |   | 3. Time of Death  |  |  |
| Gordon Alton Dring   |  | May 4 2012  |                                |   |   | 1:30 PM   |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |                                |   |   | 4c. County of Death   |  |  |
| Sinai Hospital of Baltimore  |  | Baltimore   |                                |   |   |   |  |  |
| 5. Social Security Number  |  | 6. Sex  | 7. Age (in yrs. last birthday) | If Under 1 Year   | If Under 24 Hrs.  | 8. Date of Birth<br>(Month, Day, Year)  | 9. Birthplace (State or Foreign Country) |  |
| 121-16-1307<br>Usual Residence of Decedent   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 88 Yrs.                        | Months  | Days  | 01/04/1924  | New York                                 |  |
| 10a. State   |  | 10b. County   |                                | 10c. City, Town or Location   |   |   |  |  |
| MD   |  | Baltimore   |                                | Baltimore   |   |   |  |  |
| 10e. Street and Number   |  | 10f. Zip Code   |                                |   |   | 10g. Citizen of What Country?   |  |  |
| 8810 Walther Blvd. - Apt. 1216   |  | 21234   |                                |   |   | U.S.A.  |  |  |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |   |   |  | 14. Race - American Indian, Black, White, etc. |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korean   |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                            |   |   |  | Specify: White                                 |
| 15. Decedent's Education<br>(Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |                                |   |   | 16b. Kind of Business/Industry  |  |  |
| Elementary/Secondary (0-12) 12   |  | Asst. General Steel Making Utilities  |                                |   |   | Bethlehem Steel Co.   |  |  |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |   |   |   |  |  |
| George Allen Dring   |  | Elsie Horton  |                                |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |   |   |   |  |  |
| Catherine J. Dring (wife)  |  | 8810 Walther Blvd.-Apt. 1216 - Baltimore, MD 21234  |                                |   |   |   |  |  |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date  |   | 20c. Location - City or Town, State   |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Gardens of Faith Cem.   |                                | 05/09/2012  |   | Baltimore, Maryland   |  |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility  |                                |   |   |   |  |  |
|   |  | E. F. Lassahn Funeral Home, P.A.<br>11750 Belair Road - Kingsville, Maryland 21087  |                                |   |   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  | 23b. Approximate Interval Between Onset and Death   |                                |   |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | Aspiration pneumonia  |                                |   |   | 10 days   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |                                |   |   | <p><i>CERTIFICATION APPROVED BY MEDICAL EXAMINER</i></p>  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                |   |   | 23d. Date of delivery<br>Month Day Year   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><i>Dysphagia, Clostridium difficile colitis</i>  |  |   |                                |   |   | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown         |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                                |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner? #12-3459  |  | 26. Place of Death (Check only one)   |                                |   |   |   |  |  |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice                             |                                |   |   |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br>Oct 16, 2011   |                                | 28b. Time of injury<br>Unknown  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>fall   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>nursing home   |  |   |                                |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>8832 Walter Boulevard, Parkville, MD                        |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |   |   |   |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D70334   |                                |   |   | 29d. Date signed (Month, Day, Year)<br>May 4, 2012  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |                                |   |   |   |  |  |
| Lijun Zhou MD 2401 W Belvedere Ave. Baltimore MD 21215   |  |   |                                |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 2012   |  | 32. Registrar's Signature<br>  |                                |   |   |   |  |  |

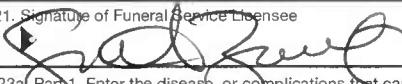
## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15343

1- For  
State  
Registrar

|   |  |  |                                      |  |  |   |   |  |   |  |   |  |
|---|--|--|--------------------------------------|--|--|---|---|--|---|--|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM GERARD DAVIS</b>  |  |                                      |  |  |   |   | 2. Date of Death<br>Month <b>5</b> Day <b>10</b> Year <b>2012</b>  |   |  | 3. Time of Death<br><b>643 A M</b>                                      |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>FRANKLIN Square Hospital</b>  |  |                                      |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   |   | 4c. County of Death<br><b>Baltimore</b>  |   |  |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>214-40-3426</b>  |  | 6. Sex<br><b>M</b>                   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                       | 8. Date of Birth<br>(Month, Day, Year)<br><b>APRIL 20, 1942</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   |  |   |  |
|   | Usual Residence of Decedent<br><b>MD.</b>  |  | 10a. State<br><b>MD.</b> 10b. County |  |  | 10c. City, Town or Location<br><b>BALTIMORE</b> |   |  | 10d. Inside City Limits<br><b>Yes</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| <b>To Be Completed by Funeral Director</b>                                | 10e. Street and Number<br><b>4254 NICHOLAS AVENUE</b>  |  |                                      |  | 10f. Zip Code<br><b>21206</b>  |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1962-1964</b>  |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:       |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b>  |  |                                      |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>TICKET AGENT</b>  |   |   | 16b. Kind of Business/Industry<br><b>MARC RAILROAD</b>   |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM J. DAVIS</b>   |  |                                      |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ISABELLE CHASON</b>  |   |   |  |   |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 19a. Informant's Name/Relationship (Type, Print)<br><b>CATHERINE W. DAVIS</b> SPOUSE   |  |                                      |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4254 NICHOLAS AVENUE BALTO. MD. 21206</b>  |   |   |  |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>   |   |   | Date<br><b>5-16-2012</b>   | 20c. Location - City or Town, State<br><b>OWINGS MILLES, MD.</b>  |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 21. Signature of Funeral Service Licensee<br>   |  |                                      |  | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME, INC.</b><br><b>9705 BELAIR ROAD NOTTINGHAM, MD. 21236</b>   |   |   |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |                                      |  | 23b. Due to (or as a consequence of):<br><b>Pneumonia</b>  |   |   | Approximate Interval Between Onset and Death   |   |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  |                                      |  | 23d. Date of delivery<br>Month Day Year  |   |   |  |   |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |   |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                      |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  |                                      |  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury<br/>M</b><br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)                                   |   |  |   |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                      |  | 29c. License number<br><b>RES0000</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>5-10-2012</b>  |   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR ASHLEY BLACKLEDGE 9000 FRANKLIN SQUARE DR BALTIMORE MD 21237</b>   |  |                                      |  | 32. Registrar's Signature<br>   |   |   |  |   |  |   |  |
| <b>Division of Vital Records, P.O. Box 68760</b>                          | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  |                                      |  | 33. Registrar's Signature<br>   |   |   |  |   |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

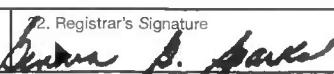
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15344

1 - For  
State  
Registrar

|   |  |   |   |                           |  |  |  |   |
|---|--|---|---|---------------------------|--|--|--|---|
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 1. Decedent's Name (First, Middle, Last)<br><b>Judith Bost Daly</b>  |   |   |                           | 2. Date of Death<br>Month <b>May</b> Day <b>8</b> , Year <b>2012</b>                               | 3. Time of Death<br>6:45 PM                                      |  |   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>National Lutheran Home</b>  |   |   |                           | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>506-40-2045</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 2, 1935</b>    | 9. Birthplace (State or Foreign Country)<br><b>Nebraska</b>  |   |
| <b>To Be Completed by Funeral Director</b>                                | 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Potomac</b>  |   |   |                           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |
|   | 10e. Street and Number<br><b>9313 Wooden Bridge Road</b>   |   |   |                           | 10f. Zip Code<br><b>20854</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                           |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |                           |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Wilson Bost</b>  |   |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harriet Lindsay Bowen</b>                  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Frederick T. Daly /Husband</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9313 Wooden Bridge Road, Potomac, Maryland 20854</b>  |                           |  |  |  |   |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |                           | Date<br><b>May 12, 2012</b>  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b> |  |   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br/>300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>   |                           |  |  |  |   |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |   |   |                           |  |  | Approximate Interval Between Onset and Death   |   |
|   | a. Due to (or as a consequence of):<br><b>Hypertension</b>   |   |   |                           |  |  |  |   |
|   | b. Due to (or as a consequence of):  |   |   |                           |  |  |  |   |
|   | c. Due to (or as a consequence of):  |   |   |                           |  |  |  |   |
|   | d. _____   |   |   |                           |  |  |  |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |                           |  |  | 23d. Date of delivery<br>Month Day Year  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                           |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
|   |  |   |   |                           |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |                           |  |  |  |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               | 28d. Describe how injury occurred                                |  |   |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |                           |  |  |  |   |
|   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D0057574</b>  |                           |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ahmed Heshmat, M.D. 2401 Research Blvd., Rockville, Maryland 20850</b>  |   |   |                           |  |  |  |   |
| <b>State<br/>Registrar</b>  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   | 32. Registrar's Signature<br>  |                           |  |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15345

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | DICARA IRMA  |  |   |  | 2. Date of Death<br>Month Day Year                               | 3. Time of Death                                     |
| 4a. Facility Name (If not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death   |  |  |  |
| 624 47th Street  |  | Harbor View  |  | Baltimore   |  |  |  |
| 5. Social Security Number  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>83 Yrs.  | If Under 1 Year<br>Months Days Hours Min.   |  |  |  |
| 220-20-6119  |  |  |  |   |  |  |  |
| Usual Residence of Decedent  |  |  |  |   |  | 8. Date of Birth<br>(Month, Day, Year)<br>Jan 2, 1929            |  |
| 10a. State<br>MD   |  | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Harbor View |   |  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |  |  |
| 10e. Street and Number<br>624 47th Street  |  | 10f. Zip Code<br>21224   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |  | 16b. Kind of Business/Industry<br>City Hospital   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Anthony   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Castagnera Theresa Berzetti   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Frank DiCara - husband   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>624 47th Street Baltimore MD 21224  |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>OAKLAWN CEMETERY   |  | Date<br>5-17-2012   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland       |  |
| 21. Signature of Funeral Service Licensee<br>Chalf Zanino  |  | 22. Name and Address of Facility<br>Joseph N Zanino TRFH<br>263 South Cowling St Baltimore MD 21224  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>ALZHEIMER'S DISEASE<br>Approximate Interval Between Onset and Death<br>16 YEARS  |  |  |  |   |  |  |  |
| a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. _____  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day Year)<br>MAY 14 2012  |  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                                |  |
| 5 <input type="checkbox"/> Pending investigation<br>6 <input type="checkbox"/> Could not be determined   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29c. License number MARYLAND<br>D0067635   |  | 29d. Date signed (Month, Day, Year)<br>MAY 14 2012  |  |  |  |
| 29b. Signature and title of certifier<br>Jessica Colburn, MD   |  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JESSICA COLBURN, MD 5505 BANNIEN CIRCLE BALTIMORE, MD 21224  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>Suzanne P. Parker   |  |   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15346

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |
|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month May Day 11 Year 2012   | 3. Time of Death<br>9:30 A M  |
| Edwin Roger Fitzgerald   |  |  |   |
| 4a. Facility Name (if not institution, give street and number)<br>Gilchrist Center   |  | 4b. City, Town, or Location of Death<br>Towson   |   |
| 4c. County of Death<br>Baltimore   |  |  |   |
| 5. Social Security Number<br>394-18-2959   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>88 Yrs.   |
|  |  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.   |
|  |  |  |   |
|  |  | 8. Date of Birth<br>(Month, Day, Year)<br>July 14, 1923  |   |
|  |  | 9. Birthplace (State or Foreign Country)<br>Wisconsin  |   |
| 10a. State<br>Maryland   |  | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Parkton  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
| 10e. Street and Number<br>2445 Traceys Store Road  |  | 10f. Zip Code<br>21120   | 10g. Citizen of What Country?<br>United States  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>5+  | 16b. Kind of Business Industry<br>Professor   |
|  |  |  | Johns Hopkins   |
| 17. Father's Name (First, Middle, Last)<br>James C. Fitzgerald   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edwina Brown  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Carolyn Fitzgerald/Wife  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2445 Traceys Store Rd., Parkton, Maryland 21120   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory Inc  | Date<br>05/12/2012  |
| 21. Signature of Funeral Service Licensee<br>Alyson K Taylor<br><i>Alyson K Taylor</i>   |  | 22. Name and Address of Facility<br>Cremation Society of Maryland Inc<br>299 Frederick Road, Baltimore, Maryland 21228   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><i>Cerebrovascular Accident</i>  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |
| a. Due to (or as a consequence of):<br><i>Cerebrovascular Accident</i>   |  |  |   |
| b. Due to (or as a consequence of):  |  |  |   |
| c. Due to (or as a consequence of):  |  |  |   |
| d. _____   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown          |   |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Parkinson's Disease</i>   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i> |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  |
|  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><i>D0071287</i>   |   |
| 29b. Signature and title of certifier<br><i>M.D.</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>5-11-12</i>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Philip Shaheen, 6701 N. Charles St. #4105, Baltimore, MD 21204</i>  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>MAY 15 2012</i>  |  | 32. Registrar's Signature<br><i>Susan J. Parks</i>   |   |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15347

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY, FRIEDRICHSEN

2. Date of Death

Month

05 Day

12 Year

3. Time of Death

950 AM

4a. Facility Name (if not institution, give street and number)  
JOHNS HOPKINS BAYVIEW  
LAKESIDE MEDICAL UNIT

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE CITY

5. Social Security Number

503-12-1257

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12/21/1924

9. Birthplace (State or Foreign Country)

Maryland

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify) \_\_\_\_\_  
9  Unknown23d. Date of delivery  
Month Day Year25. Was case referred to medical examiner?  
1  Yes 2  No26. Place of Death (Check only one)  
Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify) *Subacute facility*

27. Manner of Death

Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*R. McNeil M.D.*

29c. License number

D72168

29d. Date signed (Month Day, Year)

05/12/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
5505 HOPKINS BAYVIEW CIR  
BALTIMORE MD 21224*ROBERT MCNEIL*

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

*Susan A. Parker*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

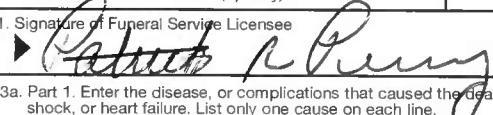
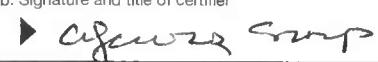
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15318

3:30P M

|  |  |  |  |   |                                       |   |  |  |   |   |  |
|--|--|--|--|---|---------------------------------------|---|--|--|---|---|--|
| 1- For State Registrar   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Fitzsimmons</b>  |  |   |                                       | 2. Date of Death<br>Month <b>May</b> Day <b>14</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>3:30P M</b>   |   |   |  |
| Physician/ Medical Examiner  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Ruxton / Manor Care</b>   |  |   |                                       | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |   |   |  |
| Funeral Director   |  | 5. Social Security Number<br><b>218-26-2122</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months<br><b>0</b> | If Under 24 Hrs.<br>Hours<br><b>0</b>   | If Under 24 Hrs.<br>Min.<br><b>0</b>                       | 8. Date of Birth<br>(Month Day, Year)<br><b>Sept. 19, 1929</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |   |  |
| To Be Completed by Funeral Director                                |  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Baltimore</b>   |  |   |                                       | 10c. City, Town or Location<br><b>Middle River</b>  |  |  |   |   |  |
|  |  | 10e. Street and Number<br><b>105 Yawmeter Drive</b>  |  |   |                                       | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)   |  |   |                                       | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>own home</b>  |   |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Artist Bowers</b>  |  |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Colemary</b>  |  |  |   |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy Dorsey /daughter</b>  |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 Yawmeter Drive Balto. MD 21220</b>  |  |  |   |   |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>  |                                       | Date<br><b>5/17/2012</b>  | 20c. Location - City or Town, State<br><b>Baltimore MD</b> |  |   |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  |  |   |                                       | 22. Name and Address of Facility<br><b>300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221</b>  |  |  |   |   |  |
| Physician/ Medical Examiner  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic Cancer</b><br>Approximate Interval Between Onset and Death   |  |   |                                       |   |  |  |   |   |  |
|  |  | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br><b>Pancreatic Cancer</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):                                    |  |   |                                       |   |  |  |   |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |                                       |   |  | 23d. Date of delivery<br>Month Day Year  |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><b>Diabetes mellitus</b><br><b>Chronic kidney Disease</b>  |  |   |                                       |   |  |  |   |   |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |                                       | 26. Place of Death (Check only one)<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M              | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                          | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                       |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                       |   |  |  |   |   |  |
|  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>R125808</b>   |                                       | 29d. Date signed (Month, Day, Year)<br><b>05-14-2012</b>  |  |  |   |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anne Lewis CRNP</b><br><b>60701 N. Charles St. Ste 4105 Baltimore, MD 21204</b>   |  |   |                                       |   |  |  |   |   |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |                                       |   |  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

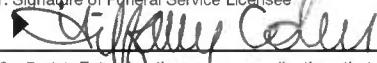
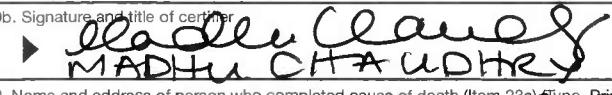
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15349

1- For  
State  
Registrar

|  |  |  |   |  |  |                                      |   |                             |  |   |  |
|--|--|--|---|--|--|--------------------------------------|---|-----------------------------|--|---|--|
| Physician/<br>Medical<br>Examiner                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Merle Flowers</b>  |   |  |  |                                      | 2. Date of Death<br>Month<br><b>May</b>   | Day<br><b>11,</b>           | Year<br><b>2012</b>  | 3. Time of Death<br><b>10:00 P M</b>  |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>16932 Flickerwood Road</b>  |   |  |  |                                      | 4b. City, Town, or Location of Death<br><b>Parkton</b>  |                             |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  |  | 5. Social Security Number<br><b>182-32-4101</b>  | 6. Sex<br><b>XXM</b> 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>71</b><br>Yrs.  | If Under 1 Year<br>Months<br><b>0</b>                      | If Under 24 Hrs.<br>Days<br><b>0</b> | Hours<br><b>0</b>   | Min.<br><b>0</b>            | 8. Date of Birth<br>(Month, Day, Year)<br><b>October 26, 1940</b>                      | 9. Birthplace (State or Foreign Country)<br><b>Hanover, PA</b>  |  |
| To Be Completed by Funeral Director                                |  | Usual Residence of Decedent<br>10a. State<br><b>Maryland</b>   |   |  |  |                                      | 10b. County<br><b>Baltimore</b>   |                             |  | 10c. City, Town or Location<br><b>Parkton</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  |  | 10e. Street and Number<br><b>16932 Flickerwood Road</b>  |   |  |  |                                      | 10f. Zip Code<br><b>21120</b>   |                             |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give ..<br>Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> | 14. Race - American Indian, Black, White, etc.<br>Specify: |                                      |   |                             |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Seconday (0-12)<br><b>12</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>1</b>             | 16b. Kind of Business Industry<br><b>Wholesale Flower Salesman</b>   | Claymore C. Sieck  |                                      |   |                             |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Emory Kenneth Flowers</b>  |   |  |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rita K. Trostle</b>   |                             |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cheryl Zetlmeisl (Companion)</b>  |   |  |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16932 Flickerwood Road Parkton, Maryland 21120</b>  |                             |  |   |  |
|  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Evans Funeral Chapel-Bel Air</b>   |   |  |  |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evans Funeral Chapel-Bel Air</b>   | Date<br><b>May 15, 2012</b> | 20c. Location - City or Town, State<br><b>Forest Hill, Maryland</b>                    |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>   |   |  |  |                                      | 22. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services Monkton 16924 York Road Monkton, Maryland 21111</b>  |                             |  |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   |  |  |                                      | Approximate Interval Between Onset and Death<br><b>12 months</b>  |                             |  |   |  |
|  |  | <p>a. Due to (or as a consequence of):<br/><b>Bladder Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |   |  |  |                                      |   |                             |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   |  |  |                                      | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                             |  | 23d. Date of delivery<br>Month Day Year   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |                                      | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                             |  |   |  |
|  |  |  |   |  |  |                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| State Registrar  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                             |  |   |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |   |  |  |                                      | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury         | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |
|  |  |  |   |  |  |                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |                                      |   |                             |  |   |  |
|  |  | 29b. Signature and title of certifier<br><br><b>Eladie Claude MADHU CHAUDHRY</b>  |   |  |  |                                      | 29c. License number<br><b>D41406</b>  |                             |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6569 NORTH CHARLES STREET</b>   |   |  |  |                                      | <b>BALTIMORE MD 21204</b>   |                             |  |   |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   |  |  |                                      | 32. Registrar's Signature<br>  |                             |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 5, per Th, g928 6-1-12 sm

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15350

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

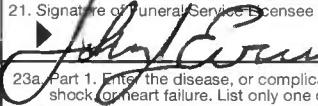
Fletcher, JEAN Allegra

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10✓

State  
Registrar

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>8:55 PM  |
| Jean Nancy Fletcher  |  | May 12, 2012  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |   | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>217-18-0392</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>07/18/1923</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Harford</b>   |   | 10c. City, Town or Location<br><b>Bel Air</b>  |
| 10e. Street and Number<br><b>700 Brier Court</b>   |  | 10f. Zip Code<br><b>21015</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:      |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |
| 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Allegra</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angelina Raimondo</b>  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Angela Fletcher Dencler, Dau.</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1527 Brierhill Estates Dr., Bel Air, MD 21015</b>   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |   | Date<br><b>05/16/2012</b>  |
| 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home<br/>610 W. MacPhail Road, Bel Air, MD 21014</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | <b>ACUTE MYOCARDIAL INFARCTION</b>  |   | Approximate Interval Between Onset and Death   |
| Due to (or as a consequence of):<br>b. _____   |  |   |   |  |
| c. _____   |  |   |   |  |
| d. _____   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEVERE SEPSIS<br/>ACUTE RENAL FAILURE</b>   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |
|  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 30263</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5-12-12</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS K. HOO M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 26, per phy, g927 5-15-12 sm  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15351

1 - For  
State  
Registrar

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>KATHARINE DIANE FAZIO</b>   |  |   |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>10</b> , Year <b>2012</b>  | 3. Time of Death<br><b>9:32 A M</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5 GUNVIEW FARM COURT</b>  |  |   | 4b. City, Town, or Location of Death<br><b>PERRY HALL</b>  |   | 4c. County of Death<br><b>BALTO.</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-68-0205</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> rs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-30-1955</b>   | 9. Birthplace (State or Foreign<br>Country)<br><b>MARYLAND</b>          |  |
| To Be Completed by Funeral Director                                | Usual Residence of Decedent<br>10a. State <b>MD.</b> 10b. County <b>BALTO.</b> 10c. City, Town or Location <b>PERRY HALL</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
|  | 10e. Street and Number<br><b>5 GUNVIEW FARM COURT</b>  |  |   | 10f. Zip Code<br><b>21128</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>1</b><br><b>HOMEMAKER</b>  |  | 16b. Kind of Business Industry<br><b>HOME</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT T. MCMONAGLE, SR.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JOANN ROBERSON</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SALVATORE FAZIO, JR. SPOUSE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 GUNVIEW FARM COURT PERRY HALL, MD. 21128</b>  |  |   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MORELAND MEMORIAL</b>  |  | Date<br><b>5-14-2012</b>  | 20c. Location - City or Town, State<br><b>PARKVILLE, MD.</b>   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME, INC.</b><br><b>9705 BELAIR ROAD NOTTINGHAM, MD. 21236</b> |   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
|  | <p>a. <u>RESPIRATORY FAILURE</u><br/>Due to (or as a consequence of):</p> <p>b. <u>PULMONARY LYMPHANGIIC CARCINOMA 3 mos</u><br/>Due to (or as a consequence of):</p> <p>c. <u>SEROUS OVARIAN CARCINOMA</u><br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |   |  |   |  |   |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown           |  |   |  | 23d. Date of delivery<br>Month Day Year                                 |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospital</b> |  |   |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br><b>WILLIAM P. McGuire</b>   |  |   |  |   |  |
|  |  |  | 29c. License number<br><b>D16801</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>10 MAY 2012</b>   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM P. MC GUIRE 9103 FRANKLIN SQUARE DR BALTO MD</b>  |  |   |  |   |  |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Signer's Signature<br>   |  |   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15352

1 - For  
State  
Registrar

GARDNER, AGNES IONA

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

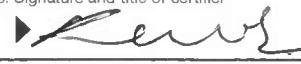
Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |  |                                |  |  |   |  |   |
|--|--|--|--------------------------------|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death   |                                |  |  | 3. Time of Death  |  |   |
| Agnes Iona Gardner   |  | May 11 2012  |                                |  |  | 8:00 PM   |  |   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |                                |  |  | 4c. County of Death   |  |   |
| Sinai Hospital of Baltimore  |  | Baltimore  |                                |  |  |   |  |   |
| 5. Social Security Number  |  | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birth (Month, Day, Year)   |  | 9. Birthplace (State or Foreign Country)                                |
| 218-48-4999  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 65 Yrs.                        | Months   | Days   | Hours   | Min.   | Maryland  |
| Usual Residence of Decedent  |  |  |                                |  |  | 02/13/47  |  |   |
| 10a. State   |  | 10b. County  |                                | 10c. City, Town or Location  |  |   |  | 10d. Inside City Limits   |
| Maryland   |  |  |                                | Baltimore  |  |   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number   |  | 10f. Zip Code  |                                |  |  | 10g. Citizen of What Country?   |  |   |
| 7301 Park Heights Ave. Apt. 204  |  | 21208  |                                |  |  | USA   |  |   |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |   | 14. Race - American Indian, Black, White, etc. |   |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |   | Specify: Black                                 |   |
| 15. Decedent's Education (Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  |                                |  |  | 16b. Kind of Business/Industry  |  |   |
| Elementary/Secondary (0-12)  |  | Application Support  |                                |  |  | Food@Drug Admin.  |  |   |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |                                |  |  |   |  |   |
| Unknown  |  | Beulah Maholmes  |                                |  |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                                |  |  | 30127   |  |   |
| Rhamana C. Smith/Sister  |  | 3237 Valley View St. Powder Springs Georgia  |                                |  |  |   |  |   |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                | Date   |  | 20c. Location - City or Town, State   |  |   |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Greenmount Cemetery  |                                | 5-16-12  |  | Baltimore, Md.  |  |   |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility   |                                |  |  | Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, Md. 21215  |  |   |
|   |  |  |                                |  |  |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | metastatic ovarian cancer  |                                |  |  | Approximate Interval Between Onset and Death 5 years  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |                                |  |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |                                |  |  | 23d. Date of delivery<br>Month Day Year   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |
|   |  |  |                                |  |  | <p>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)  |                                |  |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)   |                                | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |   |
|  |  |  |                                |  |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                                |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                |  |  |   |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number RES 000  |                                |  |  | 29d. Date signed (Month, Day, Year) May 11, 2012  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |  |                                |  |  |   |  |   |
| R. VENKATA ANGIREKULA, MBBB Sinai Hospital of Baltimore, 2401 W. Belvedere Ave Baltimore MD 21215  |  |  |                                |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)  |  | 32. Registrar's Signature   |                                |  |  |   |  |   |
| MAY 15 2012  |  |  |                                |  |  |   |  |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15353

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Greene

2. Date of Death

Month Day Year

3. Time of Death

1202 M

4a. Facility Name (if not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

253-50-9061

Usual Residence of Decedent

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 8, 1931

9. Birthplace (State or Foreign Country)

South Carolina

To Be Completed by Funeral Director

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Glendale

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

6005 King Arthur Way

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

National Geographic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Harry Brady

18. Mother's Name (First, Middle, Maiden Surname)

Zelma Brady

19a. Informant's Name/Relationship (Type, Print)

Zelda Greene /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6005 King Arthur Way Glendale, MD. 20769

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crem.

Date

20c. Location - City or Town, State

May 21, '12 Beltsville, MD

21. Signature of Funeral Service Licensee

cc278

22. Name and Address of Facility

Latney's Funeral Home  
3831 Georgia Ave. N.W. Wash. DC 2001123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Pulmonary Edema

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

Severe Mitral Regurgitation

24a. Was an autopsy performed?  
1  Yes 2  No24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No25. Was case referred to medical examiner?  
1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?  
1  Yes 2  No

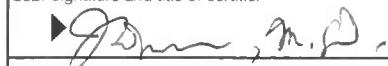
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 66249

29d. Date signed (Month, Day, Year)

May 11, 2012

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Jonathan Duran 1500 Forest Glen Road, Silver Spring MD 20910

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature



permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #20b Per FH G927 5/23/2012 JH  
 State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No.

2012 15354

|  |  |  |   |   |   |   |   |   |  |
|--|--|--|---|---|---|---|---|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Linda Grantham</b>  |  |   |   |   |   |   | 2. Date of Death<br>Month<br><b>May</b> 8 Day<br>Year<br><b>2012</b>    | 3. Time of Death<br>P.M.<br><b>3:00 P M</b>    |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Prince George's Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |   |   | 4c. County of Death<br><b>Prince George's</b>                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-98-6273</b>  |  | 6. Sex<br><b>M</b>  | 7. Age (In yrs. last birthday)<br><b>46</b><br>Yrs.   | If Under 1 Year<br>Months<br><b> </b>   | If Under 24 Hrs.<br>Hours<br><b> </b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec 16 1965</b>    | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>       |  |
|  | Usual Residence of Decedent<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   |   |   | 10b. County<br><b>Prince George's</b>   |   |   | 10c. City, Town or Location<br><b>Landover</b> |
| 10e. Street and Number<br><b>2602 Pinebrook Avenue #B-2</b>        |  |  |   |   | 10f. Zip Code<br><b>20785</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
| To Be Completed by Funeral Director                                | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br> |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br>2+   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Accounts Receivable</b>  |   | 16b. Kind of Business/Industry<br><b>Private</b>  |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles M. Carr</b>  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Linda M. Welch</b>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elijah Grantham Jr./Husband</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2602 Pinebrook Avenue, #B-2, Landover, Maryland 20785</b> |   |   |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>  |   |   | Date<br><b>5/18/2012</b>  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b> |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>lysgr</b>  |  |   | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, Maryland 20785</b>   |   |   |   |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |   | Approximate Interval Between Onset and Death  |   |   |  |
|  | <p>a. Due to (or as a consequence of):<br/><b>Hypoxic Encephalopathy</b></p> <p>b. Due to (or as a consequence of):<br/><b>Fatal cardiac arrhythmia</b></p> <p>c. Due to (or as a consequence of):<br/><b>Congestive Heart Failure</b></p> <p>d. Due to (or as a consequence of):<br/><b>Diabetes</b></p>  |  |   |   |   |   |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year   |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |
|  |  |  |   |   |   | <p>24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> |   |   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |   |   |   |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred                               |   |  |
|  |  |  |   |   |   |   |   |   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |
|  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Only one |  | 29c. License number<br><b>P30318</b>  |   |   |   |   |   |  |
|  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/12</b>  |   |   |   |   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Catervenius 3001 Hospital Dr Cheverly MD 20785</b>  |  |   |   |   |   |   |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>James P. Farrel</b>   |   |   |   |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15355

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1000609955 Gilley, Janet DOD 5/11/12

State  
Registrar

DHMH 17 Rev 06-2011

|   |  |   |   |   |
|---|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month 5 Day 11 Year 2012  |   | 3. Time of Death<br>0558 AM   |
| Janet Garrity Gilley  |  |   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br>Upper Chesapeake Med Ctr  |  | 4b. City, Town, or Location of Death<br>Bel Air, MD   |   | 4c. County of Death<br>Harford  |
| 5. Social Security Number<br>218-46-2965  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>64 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>October 17, 1947  |
| 9. Birthplace (State or Foreign Country)<br>Havre de Grace, Maryland  |  |   |   |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Harford  |   | 10c. City, Town or Location<br>Street   |
|   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br>3741 Bay Road   |  | 10f. Zip Code<br>21154  |   | 10g. Citizen of What Country?<br>U.S.A.   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |   |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Food Services   |   | 16b. Kind of Business/Industry<br>Harford County Public Schools   |
| 17. Father's Name (First, Middle, Last)<br>Richard Harold Garrity   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ruth Marie Burns   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Roy G. Gilley (Spouse)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3741 Bay Road, Street, Maryland 21154  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens  |   | 20c. Date<br>May 15, 2012   |
| 20d. Location - City or Town, State<br>Bel Air, Maryland  |  |   |   |   |
| 21. Signature of Funeral Service Licensee<br>Jeffrey R. Testerman (M01543)  |  | 22. Name and Address of Facility<br>Evans Funeral Chapel & Cremation Services - Bel Air<br>3 Newport Drive, Forest Hill, Maryland 21050   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br>2 weeks   |   |   |
| a. Due to (or as a consequence of):<br>Metastatic Adenocarcinoma  |  |   |   |   |
| b. Due to (or as a consequence of):   |  |   |   |   |
| c. Due to (or as a consequence of):   |  |   |   |   |
| d. Due to (or as a consequence of):   |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  |
|   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |
| 29b. Signature and title of certifier<br>Carolyn B. O'Connor MD   |  | 29c. License number<br>D0062445   |   | 29d. Date signed (Month, Day, Year)<br>5-11-2012  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Carolyn B. O'Connor MD Upper Chesapeake Med Ctr, Bel Air MD   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012  |  | 32. Registrar's Signature<br>Linda J. Parker  |   |   |

ORIGINAL

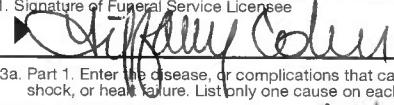
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15356

1 - For  
State  
Registrar

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Shirley Crawford Gianotti</b>  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 13, 2012</b>          | 3. Time of Death<br>3:30A M  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Joseph Medical Center</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |  | 4c. County of Death<br><b>Baltimore</b>                            |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-32-7340</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>75</b><br>Yrs.  | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>December 15, 1936</b> | 9. Birthplace (State or Foreign Country)<br><b>Whitehall, MD</b>                               |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Parkville</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>1941 Mountain Avenue</b>   |  |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>              |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Seconday (0-12) 7</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Electrical Technician</b> |  | 16b. Kind of Business Industry<br><b>Westinghouse Benedix</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frank William Arney</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth B. Flanagan</b>   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonnie Rettman (Daughter)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2518 Wucliffe Road Parkville, Maryland 21234</b> |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>  |  | Date<br><b>May 17, 2012</b>  | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 21. Signature of Funeral Service Licensee<br>   |  |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services-Parkville<br/>8800 Harford Road Parkville, Maryland 21234</b>   |  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of): <b>metastatic poorly differentiated lung cancer</b>   |  |  |  |  |  |  |  |
|  | b. Due to (or as a consequence of):   |  |  |  |  |  |  |  |
|  | c. Due to (or as a consequence of):   |  |  |  |  |  |  |  |
|  | d. _____  |  |  |  |  |  |  |  |
|  | Approximate Interval Between Onset and Death  |  |  |  |  |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
|  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  |  |  |  |  |  |  |
|  | 28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> <b>28c. Injury at work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |  |
|  | 28d. Describe how injury occurred<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
|  | 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier <b>Richard L. Lituski MD</b> <b>29c. License number D36814</b> <b>29d. Date signed (Month, Day, Year) 5/14/12</b>   |  |  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Richard Lituski 1734 York Road, Lutherville, MD 21093</b>  |  |  |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><b>Suzanne B. Jacobs</b>  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15357

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Rosemary Ann Gauza</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>09</b> Year <b>2012</b>  |  | 3. Time of Death<br>3:09 p.m.   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| 5. Social Security Number<br><b>216-72-5799</b>   |  | 6. Sex<br><b>M</b>   |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.  |  |
| 8. If Under 1 Year<br>Months _____ Days _____   |  | 9. If Under 24 Hrs.<br>Hours _____ Min. _____  |  | 10. Date of Birth<br>(Month, Day, Year)<br><b>January 06, 1960</b>  |  |
| 11. Usual Residence of Decedent<br><b>Maryland</b>  |  | 12. Sex<br><b>M</b>  |  | 13. Date of Birth<br>(Month, Day, Year)<br><b>January 06, 1960</b>  |  |
| 14. Social Security Number<br><b>216-72-5799</b>  |  | 15. Age (In yrs. last birthday)<br><b>52</b> Yrs.  |  | 16. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
| 17. Street and Number<br><b>4306 Halbert Avenue</b>   |  | 18. Zip Code<br><b>21236</b>   |  | 19. Citizen of What Country?<br><b>United States</b>  |  |
| 20. State<br><b>Maryland</b>  |  | 21. County<br><b>Baltimore</b>   |  | 22. City, Town or Location<br><b>Perry Hall</b>   |  |
| 23. City, Town or Location<br><b>Perry Hall</b>   |  | 24. Inside City Limits<br><b>Yes</b>   |  | 25. Outside City Limits<br><b>No</b>  |  |
| 26. Marital Status<br><b>X Never Married</b>  |  | 27. Was Decedent Ever in U.S. Armed Forces?<br><b>Yes</b>  |  | 28. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><b>No</b>   |  |
| 29. Widowed<br><b>No</b>  |  | 30. Divorced<br><b>No</b>  |  | 31. Specify:<br><b>White</b>  |  |
| 32. Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 33. Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Elementary School Teacher</b>   |  | 34. Kind of Business/Industry<br><b>Baltimore County Public School</b>  |  |
| 35. Grade Completed<br><b>12</b>  |  | 36. Grade Retained<br><b>5</b>   |  | 37. Maiden Surname<br><b>Hiedzianowski</b>  |  |
| 38. Father's Name (First, Middle, Last)<br><b>Stephen J. Gauza</b>  |  | 39. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Rose Miedzianowski</b>   |  | 40. Informant's Name/Relationship (Type, Print)<br><b>Wendy Browning (Cousin)</b>   |  |
| 41. Relationship<br><b>Cousin</b>   |  | 42. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4306 Halbert Avenue Perry Hall, Maryland 21236</b>  |  | 43. Method of Disposition<br><b>Burial</b>  |  |
| 44. Cremation<br><b>No</b>  |  | 45. Removal from State<br><b>No</b>  |  | 46. Donation<br><b>No</b>   |  |
| 47. Other (Specify)<br><b>None</b>  |  | 48. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Rosary Cemetery</b>   |  | 49. Date<br><b>May 14, 2012</b>   |  |
| 50. Signature of Funeral Service Licensee<br><b>Sally Coley</b>   |  | 51. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services Parkville 8800 Hartford Road Parkville, Maryland 21234</b>  |  | 52. Location - City or Town, State<br><b>Dundalk, Maryland</b>  |  |
| 53. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrest</b>  |  | 54. Approximate Interval Between Onset and Death   |  |   |  |
| 55. Due to (or as a consequence of):<br><b>None</b>   |  | 56. Due to (or as a consequence of):<br><b>None</b>  |  | 57. Due to (or as a consequence of):<br><b>None</b>   |  |
| 58. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>Yes</b>   |  | 59. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 60. Date of delivery<br>Month Day Year  |  |
| 61. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 62. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 63. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 64. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 65. Hospital:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA   |  | 66. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 67. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 68a. Date of injury<br>(Month, Day, Year)<br>M   |  | 68b. Time of injury<br>M  |  |
| 69. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 70. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 71. Describe how injury occurred  |  |
| 72. Signature and title of certifier<br><b>Nathan A. Dunsmore, M.D.</b>   |  | 73. License number<br><b>D43003</b>  |  | 74. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>   |  |
| 75. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nathan A. Dunsmore, M.D. 6701 N. Charles St, Towson, MD 21204</b>  |  | 76. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 77. Registrar signature<br><b>[Signature]</b>   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

*Jauza, Rosemary*  
Baltimore, Maryland 21215-0036

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

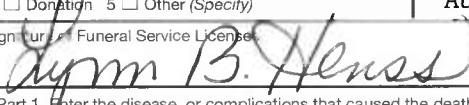
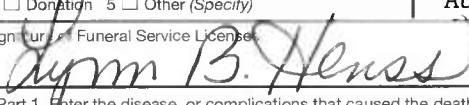
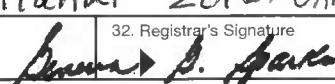
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15358

1 - For  
State  
Registrar

|                                     |  |  |   |   |  |   |  |   |  |  |  |  |  |  |
|-------------------------------------|--|--|---|---|--|---|--|---|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Diane Glassmyer</b>   |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>2038 PM</b>  |  |  |  |  |  |  |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br><b>Union Memorial Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |  |  |  |  |  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br><b>214-46-8910</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months<br>Days  | If Under 24 Hrs.<br>Hours<br>Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>October 14, 1946</b>                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                 |  |  |  |  |  |  |
|                                     |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |
|                                     |  | 10e. Street and Number<br><b>3702 Chestnut Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21211</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                 |  |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                 |  |  |  |  |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Fiscal Technician</b> |   |  | 16b. Kind of Business/Industry<br><b>Enoch Pratt Library Baltimore City</b> |  |  |  |  |  |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>John Wilbert Durner</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosella May Wiley</b>   |  |   |  |  |  |  |  |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Annette Heine Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2807 Gilford Avenue Baltimore, Maryland 21218</b>   |  |   |  |   |  |  |  |  |  |  |
|                                     |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |  | Date<br><b>5/14/2012</b>  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>              |   |  |  |  |  |  |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Burgee-Hennis-Seitz Funeral Home, Inc. 21211<br/>3631 Falls Road Baltimore, Maryland</b>   |  |   |  |   |  |  |  |  |  |  |
|                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, <b>if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>   |   |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |  |
|                                     |  | <p>a. <b>Pneumonia</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |   |   |  |   |  |   |  |  |  |  |  |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |  |
|                                     |  |  |   |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 26. Place of Death (Check only one)   |  |  |  |  |  |  |
|                                     |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |  |  |  |  |
|                                     |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br><b>ATZ438946</b>   |  |   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b>  |  |  |  |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sreenath Vellanki 201 E. University Pkwy, Baltimore, MD 21218</b>   |   |   |  |   |  |   |  |  |  |  |  |  |
| State<br>Registrar                  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   | 32. Registrar's Signature<br>  |  |   |  |   |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15359

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death<br>11:59 PM   |
| Kathleen Armstrong Gale  |  | May 9, 2012  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist</b>   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |   | 4c. County of Death<br><b>Howard</b>   |
| 5. Social Security Number<br><b>042-34-8780</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>If Under 24 Hrs.<br>Hours Min.  |
| 8. Date of Birth (Month, Day, Year)<br><b>Apr 28, 1943</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10c. City, Town or Location<br><b>Elkridge</b>   |  | 10f. Zip Code<br><b>21075</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>2</b>   |   | 16b. Kind of Business/Industry<br><b>Healthcare</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>James Wheeler Armstrong, Jr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vivian Bernice Hightower</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wendy Gale / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8009 Keeton Rd. Elkridge, MD 21075</b>   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Final Journey Crematory</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MO1251</b>  |   | Date<br><b>5/14/2012</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Beverly L. Heckrotte</b>   |  | 22. Name and Address of Facility<br><b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>  |   | 20c. Location - City or Town, State<br><b>Woodbine, Maryland</b>   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>CHOLANGIOCARCINOMA</b><br>Due to (or as a consequence of):   |   | Approximate Interval Between Onset and Death<br><b>MARCH 2012</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. _____<br>Due to (or as a consequence of):   |   |  |
|  |  | c. _____<br>Due to (or as a consequence of):   |   |  |
|  |  | d. _____   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown                      |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |
|  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>HOSPICE</b> |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D64395</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 10, 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANIELLE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, MD 21044</b>  |  | 32. Registrar's Signature<br><b>Jane S. Gale</b>   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 33. Date signed (Month, Day, Year)   |   |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15360

1 - For  
State  
Registrar

|  |   |                           |   |                           |  |  |  |   |  |  |
|--|---|---------------------------|---|---------------------------|--|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>THEODORE J. GRUMBINE</b>   |                           |   |                           |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>13</b> , Year <b>2012</b> | 3. Time of Death<br><b>12:50 A M</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>GILCHRIST HOSPICE</b>  |                           |   |                           | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  |  | 4c. County of Death<br><b>BALTO.</b>                                  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-24-7992</b>   | 6. Sex<br><b>1 XM 2 F</b> | 7. Age (In yrs. last birthday)<br><b>85</b><br>Yrs.   | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>1-18-1927</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD.</b>  |                           | 10b. County<br><b>BALTO.</b>  |                           | 10c. City, Town or Location<br><b>NOTTINGHAM</b>   |  |  |   | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b>   |  |
|  | 10e. Street and Number<br><b>9514 DAWNVALE ROAD</b>   |                           |   |                           | 10f. Zip Code<br><b>21236</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                           |  |  |
|  | 11. Marital Status<br><b>1 □ Never Married 2 X Married<br/>3 □ Widowed 4 □ Divorced</b>   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 2 □ No<br/>If Yes, Give Year or Dates. <b>1945-1946</b></b> |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No Specify:</b>                          |  |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>        |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |                           |   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHEMIST</b>  |  |  | 16b. Kind of Business/Industry<br><b>PAINT COMPANY</b>                |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES J. GRUMBINE</b>   |                           |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORENCE HART</b>  |  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>WINIFRED B. GRUMBINE</b>   |                           |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SPouse 9514 DAWNVALE ROAD NOTTINGHAM, MD. 21236</b>                |  |  |   |  |  |
|  | 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>   |                           |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH</b>  |  | Date<br><b>5-16-2012</b>   | 20c. Location - City or Town, State<br><b>FULLERTON, MD.</b>          |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Winifred B. Grumbine</i>  |                           |   |                           | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME, INC.<br/>9705 BELAIR ROAD NOTTINGHAM, MD. 21236</b>   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                           |   |                           |  |  |  |   | Approximate Interval Between Onset and Death<br><b>Weeks</b>   |  |
|  | <p>a. <u>Complications of Hip fracture</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Dementia</u><br/>Due to (or as a consequence of):</p> <p>c. <u>Arthritis</u><br/>Due to (or as a consequence of):</p> <p>d. <u>Arteriosclerosis</u><br/>Due to (or as a consequence of):</p>   |                           |   |                           |  |  |  |   |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No<br/>9 □ Unknown</b>  |                           |   |                           | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (Specify)<br/>9 □ Unknown</b> |  |  | 23d. Date of delivery<br>Month Day Year                               |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                           |   |                           |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown</b>   |  |
|  |   |                           |   |                           |  |  |  |   | <p>24a. Was an autopsy performed?<br/><b>1 □ Yes 2 X No</b></p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><b>1 □ Yes 2 X No</b></p> |  |
|  | 25. Was case referred to medical examiner?<br><b>1 X Yes 2 □ No</b>   |                           | Hospital:<br><b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b>   |                           | 26. Place of Death (Check only one)<br><b>Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>  |  | 27. Manner of Death<br><b>1 □ Natural 5 □ Pending Investigation<br/>2 X Accident 6 □ Could not be determined<br/>3 □ Suicide 4 □ Homicide</b>  |   |  |  |
|  |   |                           |   |                           |  |  | <p>28a. Date of injury (Month, Day, Year)<br/><b>04/26/2012</b></p> <p>28b. Time of injury<br/><b>unknown M</b></p> <p>28c. Injury at work?<br/><b>1 □ Yes 2 X No</b></p> <p>28d. Describe how injury occurred<br/><b>Fell while backing out of another patient's room</b></p> |   |  |  |
|  |   |                           |   |                           |  |  | <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br/><b>Arden Courts of Towson</b></p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br/><b>8101 Bellona Ave, Towson, MD 21204</b></p>              |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                           | 29b. Signature and title of certifier<br><i>A. Rathi, M.D.</i>  |                           | 29c. License number<br><b>D71040</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/13/12</b>  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARATHI KUMAR 6701 N CHARLES ST SUITE 4105 BALTIMORE MD</b>   |                           | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |                           | 32. Registrar's Signature<br><i>Leanne S. Gaitz</i>  |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15361

1 - For  
State  
Registrar

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Sonya J. Greco</b>  |  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>          | 3. Time of Death<br>1:59 AM  |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>                     |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>272-30-8734</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>6/26/1932</b>                   | 9. Birthplace (State or Foreign Country)<br><b>OHIO</b>  |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Severna Park</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>526 Benforest Drive West</b>  |  |  | 10f. Zip Code<br><b>21146</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesperson</b>   |   |  | 16b. Kind of Business/Industry<br><b>Retail</b>                              |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Theodore Minnich</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Clifton</b>  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Daniel Greco / Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>526 Benforest Drive West      Severna Park, MD 21146</b>   |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National</b>  |   | Date<br><b>UNK</b>   | 20c. Location - City or Town, State<br><b>Arlington, VA</b>                  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Director/Certifying Physician<br><br><b>Mo. 220</b>  |  | 22. Name and Address of Facility<br><b>Singleton Funeral &amp; Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061</b>   |   |  |  |  |  |  |
|  | 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COPD</b>   |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |
|  | b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Pneumonia</b>  |  |  |   |  |  |  |  |  |
|  | c. Due to (or as a consequence of):<br><b></b>   |  |  |   |  |  |  |  |  |
|  | d. Due to (or as a consequence of):<br><b></b>   |  |  |   |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown      |   |  | 23d. Date of delivery<br>Month      Day      Year                            |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/><br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><br><b>Keith Goulet D.O.</b>   |  | 29c. License number<br><b>H0070482</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5-13-12</b>                        |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Keith Goulet 2001 Medical Parkway Annapolis, MD</b>   |  |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15362

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

12/

1- For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Shirley Lillian Green

2. Date of Death

Month Day Year  
May 1, 2012

3. Time of Death

8:15 A M

4a. Facility Name (if not institution, give street and number)

Maplewood Park Place

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

052-16-9434

6. Sex

M

F

7. Age (In yrs. last birthday)

Yrs.

91

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 11, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

Yes  No

10e. Street and Number

9707 Old Georgetown Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

Never Married  Married

Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Historical Photo Researcher

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Harry Freundel

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Emmer

19a. Informant's Name/Relationship (Type, Print)

Stephanie Green Lawson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5405 Duvall Drive, Bethesda, Maryland 20816

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial Garden

Date

May 6, 2012 Falls Church, Virginia

21. Signature of Funeral Service Licensee

 M01360

22. Name and Address of Facility

Robert A. Pumpfrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

10 Months

Congestive Heart Failure

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?  
 Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA

Other:

Nursing Home

Residence

Other (Specify)

Assisted Living

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D57304

29d. Date signed (Month, Day, Year)

May 3, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eirene E. Koroulakis, M.D. 10810 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature



**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
 amend #10e per EH G927 5/15/2012 TH  
 State of Maryland Department of Health and Mental Hygiene

1 - For  
State  
Registrar

**Certificate of Death**

Reg. No.

2012 15363

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
 Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

|   |                        |   |  |   |  |                           |                          |  |   |
|---|------------------------|---|--|---|--|---------------------------|--------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)  |                        |   |  | 2. Date of Death  |  |                           |                          | 3. Time of Death   |   |
| MIRIAM M GOLDMAN  |                        |   |  | Month MAY 12, 2012 Day Year   |  |                           |                          | 2:50 AM  |   |
| 4a. Facility Name (if not institution, give street and number)<br><br>ROCK SPRING VILLAGE   |                        |   |  | 4b. City, Town, or Location of Death<br><br>FOREST HILL   |  |                           |                          | 4c. County of Death<br><br>HARFORD                                   |   |
| 5. Social Security Number<br><br>213-16-6342  |                        | 6. Sex<br><br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><br>92 Yrs.   |  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days | Hours  | Min.  |
| 8. Date of Birth<br><br>01/09/1920  |                        | 9. Birthplace (State or Foreign Country)<br><br>MD  |  |   |  |                           |                          |  |   |
| Usual Residence of Decedent   |                        |   |  |   |  |                           |                          |  |   |
| 10a. State<br><br>MD  | 10b. County<br><br>N/A | 10c. City, Town or Location<br><br>BALTIMORE  |  |   |  |                           |                          |  |   |
| 10e. Street and Number<br><br>7111 PARK HEIGHTS AVENUE, #305  |                        |   |  | 10f. Zip Code<br><br>21215  |  |                           |                          | 10g. Citizen of What Country?<br><br>USA                             |   |
| 11. Marital Status<br><br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                           |                          | 14. Race - American Indian, Black, White, etc.<br><br>Specify: WHITE |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><br>Elementary/Secondary (0-12) 12  |                        | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><br>College (1-4 or 5+) OWNER             |  | 16b. Kind of Business Industry<br><br>HARDWARE  |  |                           |                          |  |   |
| 17. Father's Name (First, Middle, Last)<br><br>SIMON ZESKIND  |                        |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><br>ROSE DENABURG |                           |                          |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><br>RICKY MILLER/SON  |                        |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><br>665 RED CEDAR ROAD, ANNAPOLIS, MD 21409  |  |                           |                          |  |   |
| 20a. Method of Disposition<br><br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                        |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><br>BALTIMORE HEBREW CEM  |  |                           |                          | Date<br>05/14/2012   | 20c. Location - City or Town, State<br><br>REISTERSTOWN, MD |
| 21. Signature of Funeral Service Licensee<br><br>► [Signature]  |                        |   |  | 22. Name and Address of Facility<br><br>SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208  |  |                           |                          |  |   |

**Physician/  
Medical  
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |                       |  |
|--|--|---|-----------------------|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)   |  | Lung Cancer   |                       | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):   |                       |  |
| {  |  | b. Due to (or as a consequence of):   |                       |  |
| {  |  | c. Due to (or as a consequence of):   |                       |  |
| {  |  | d. Due to (or as a consequence of):   |                       |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown   |                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23d. Date of delivery<br>Month Day Year   |                       |  |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE |                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |  | 28d. Describe how injury occurred   |                       |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                       |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                       |  |
| 29b. Signature and title of certifier<br><br>► [Signature]   |  | 29c. License number<br><br>R129525  |                       | 29d. Date signed (Month, Day, Year)<br><br>05/12/12                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><br>Craig Zylika   |  | 2 North Ave. Ste. 101 Bel Air, MD 21014   |                       |  |
| 31. Date filed (Month, Day, Year)<br><br>MAY 15 2012   |  | 32. Registrar's Signature<br><br>Sarah J. Parker  |                       |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G927, 5/15/2012, WS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15364

1 - For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Connie Sue Hill

2. Date of Death

Month May Day 10, Year 2012

3. Time of Death

1:45 A M

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

4a. Facility Name (if not institution, give street and number)

1221 Caldwell Ct. South

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

Funeral  
Director

|                           |  |                                |                 |                  |                                     |  |
|---------------------------|--|--------------------------------|-----------------|------------------|-------------------------------------|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
| 519-86-3713               | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 54 Yrs.                        | Months          | Days             | Jan 4, 1958                         | Ohio                                     |

Usual Residence of Decedent

|            |             |                             |   |
|------------|-------------|-----------------------------|---|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits   |
| Maryland   | Harford     | Belcamp                     | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |

10e. Street and Number

1221 Caldwell Ct. South

10f. Zip Code

21017

10g. Citizen of What Country?

USA

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             | Specify: White                                 |

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

Lloyd Ingram

18. Mother's Name (First, Middle, Maiden Surname)

Ina Kissling

19a. Informant's Name/Relationship (Type, Print)

Jody R. St.Clair, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1221 Caldwell Ct. South Belcamp, Maryland 21017

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Metro Crematory Inc.

05/10/12

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Thomas Gregor

22. Name and Address of Facility

Cremation Society Of Maryland, Inc.  
299 Frederick Road Baltimore, Maryland 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown24a. Was an autopsy performed?  
1  Yes 2  No24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

Sonja Ries

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Poppe Ries

MD

29c. License number

DOO658279

29d. Date signed (Month, Day, Year)

5/10/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 15 2012

32. Registrar's Signature  
Sonja S. Ries

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15365

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit envelope.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Wryant Holloway</i>   |  |   |  | 2. Date of Death<br>Month <i>May</i> Day <i>10</i> Year <i>2012</i>  |  | 3. Time of Death<br><i>1:40 P M</i>                                     |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>Northwest Seasons Hospice</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Randallstown</i>  |  | 4c. County of Death<br><i>Baltimore</i>                                 |  |
| 5. Social Security Number<br><i>219-10-5920</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>86</i> Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><i>2-9-1926</i>               | 9. Birthplace (State or Foreign Country)<br><i>N.C.</i>  |
| 10a. State<br><i>MD</i>  |  | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><i>3700 Copley Rd.</i>   |  |   |  | 10f. Zip Code<br><i>21215</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>                             |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><i>1945-1946</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><i>Black</i>  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>12th</i>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Sky Capt.</i> |  |  | 16b. Kind of Business/Industry<br><i>American Airlines</i>              |  |
| 17. Father's Name (First, Middle, Last)<br><i>Horace Holloway</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Hattie Walker</i>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Daughter<br/>Barbara J. Holloway-House</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8731 Lisa Lane Randallstown, MD 21133</i>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><i>Burial</i>   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest</i>   |  | Date<br><i>5/21/2012</i>  | 20c. Location - City or Town, State<br><i>Owings Mills, MD</i>                                 |
| 21. Signature of Funeral Service Licensee<br><i>Lynette L. Jones</i>   |  |   |  | 22. Name and Address of Facility<br>March F/H- East 110 E. North Ave<br><i>Baltimore, MD 21202</i>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>End-Stage Dementia</i>  |  |   |  |  |  |   |  |
| Approximate Interval Between Onset and Death   |  |   |  |  |  |   |  |
| <p>a. Due to (or as a consequence of):<br/><i></i></p> <p>b. Due to (or as a consequence of):<br/><i></i></p> <p>c. Due to (or as a consequence of):<br/><i></i></p> <p>d. Due to (or as a consequence of):<br/><i></i></p>  |  |   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br><i>In-patient Hospice</i> |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br><i>May</i>  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i></i>  |  |   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i></i>  |  |   |  |  |  |   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><i>DO057465</i>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><i>5/10/12</i>                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>NS Rajapakse MD 2835 Smith St 203 Baltimore MD 21209</i>  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 15 2012</i>  |  | 32. Registrar's Signature<br><i>James J. Farrel</i>   |  |  |  |   |  |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

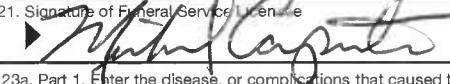
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

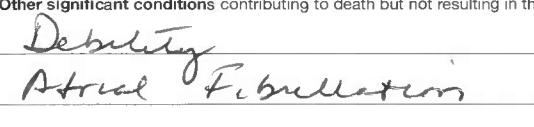
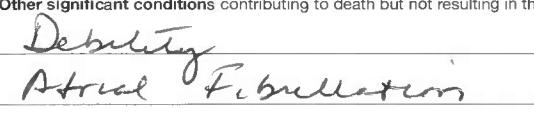
Reg. No.

2012 15366

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | Millard Raymond Hart  |   | 2. Date of Death<br>Month Day Year   | 3. Time of Death<br>6:00 p m                             |
| 4a. Facility Name (if not institution, give street and number)<br>The Maples of Towson  |  | 4b. City, Town, or Location of Death<br>Towson  |   | 4c. County of Death<br>Baltimore   |  |
| 5. Social Security Number<br>217-20-4605  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>April 26, 1927 |
| Usual Residence of Decedent<br>10a. State<br>MD   |  | 10b. County<br>N/A  |   | 10c. City, Town or Location<br>Baltimore   |  |
| 10e. Street and Number<br>3105 White Avenue   |  | 10f. Zip Code<br>21214  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Woodworker     |   | 16b. Kind of Business Industry<br>Self-Employed  |  |
| 17. Father's Name (First, Middle, Last)<br>James Fleming Hart   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katie Trader   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Millard R. Hart, Jr. (Son)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7965 Castle Hedge Dell Glen Burnie, MD 21061         |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Atlantic Crematory  |   | Date<br>5/15/2012  | 20c. Location - City or Town, State<br>Glen Burnie, MD   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Burgee-Henss-Seitz Funeral Home, Inc.<br>3631 Falls Road Balto, MD 21211  |   |  |  |

To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ |  |
|  |  |  |  | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>  |  | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>  |  | 23g. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  |
| 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>RO 79544  |  | 29d. Date signed (Month, Day, Year)<br>5/12/2012  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>6705 N. CHARLES ST. STE 4105 TOWSON, MD 21204  |  | 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>Barbara J. Baker   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15367

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Munro Head

2. Date of Death

Month

Day

Year

May 11, 2012

3. Time of Death

7:30 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

801 Post Boy Ct.

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

061-14-8592

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Jun 16, 1920

9. Birthplace (State or Foreign Country)

New York

To Be Completed by Funeral Director

Usual Residence of Decedent

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

801 Post Boy Ct.

10f. Zip Code

21286

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

President

16b. Kind of Business Industry  
The Service Employ. Agency

17. Father's Name (First, Middle, Last)

Walter T. Munro

18. Mother's Name (First, Middle, Maiden Surname)

Helen P. Pierce

19a. Informant's Name/Relationship (Type, Print)

Lynn Teret /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Post Boy Ct. Towson, MD 21286

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

May 14, 2012

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

*Ronaldine Ritter MC1443*

22. Name and Address of Facility

Cremation and Funeral Alternatives

8717 Green Pastures Drive Towson Maryland 21286

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. *Alzheimer's Dementia*  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Roger Greer*

29c. License number

D64263

29d. Date signed (Month, Day, Year)

May 14, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Roger Greer, MD 10753 Falls Road, Suite 325, Lutherville, MD 21093*

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

*Susan P. Greer*

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15368

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 marks other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Division of Vital Records, P.O. Box 68760

6/

## Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |   |                                |
|---|--|---|--------------------------------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  |                                |
| James W Hudson  |  | Month   | Day                            |
| 4a. Facility Name (if not institution, give street and number)  |  | 3. Time of Death  |                                |
| SEASONS HOSPICE   |  | May 12 2012 02:54 AM  |                                |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (in yrs. last birthday) |
| 214-30-3525   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 77 Yrs.                        |
| 8. Date of Birth (Month, Day, Year)   |  | 9. Birthplace (State or Foreign Country)  |                                |
| JULY 19, 1934   |  | MARYLAND  |                                |
| 10a. State  |  | 10b. County   | 10c. City, Town or Location    |
| MD.   |  | BALTO.  | MIDDLE RIVER                   |
| 10e. Street and Number  |  | 10f. Zip Code   |                                |
| 6821 UNIVERSITY DRIVE   |  | 21220 USA   |                                |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.   |                                |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  |                                |
| Elementary/Secondary (0-12) 12TH  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |                                |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business/Industry  |                                |
| College (1-4 or 5+) ELECTRICIAN   |  | BETHLEHEM STEEL   |                                |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |
| JAMES G. HUDSON   |  | MARY E. QUADE   |                                |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |
| LEONA HUDSON SPOUSE   |  | 6821 UNIVERSITY DRIVE MIDDLE RIVER, MD. 21220   |                                |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | ATLANTIC CREMATORY  |                                |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |
|   |  | SCHIMUNEK FUNERAL HOME, INC.<br>9705 BELAIR ROAD NOTTINGHAM, MD. 21236  |                                |
| 23a. Part 1. Enter the disease(s), complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |
| Immediate Cause (1st) disease or condition resulting in death)  |  |   |                                |
| a. Chronic Obstructive Pulmonary Disease  |  |   |                                |
| Due to (or as a consequence of):  |  |   |                                |
| b. Due to (or as a consequence of):   |  |   |                                |
| c. Due to (or as a consequence of):   |  |   |                                |
| d. Due to (or as a consequence of):   |  |   |                                |
| Approximate Interval Between Onset and Death  |  |   |                                |
| IF FEMALE:  |  | 23c. If yes, outcome of pregnancy   |                                |
| 23b. Was decedent pregnant in the past 12 months?   |  | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown    |                                |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 23d. Date of delivery   |                                |
| 23e. Month Day Year   |  |   |                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |
| Atrial fibrillation   |  |   |                                |
| 23e. Did tobacco use contribute to the cause of death?  |  |   |                                |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)   |                                |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                |
| 27. Manner of Death   |  | 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28d. Describe how injury occurred   |                                |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |
| 29b. Signature and title of certifier   |  | 29c. License number   |                                |
|   |  | D0053337  |                                |
| 29d. Date signed (Month, Day, Year)   |  |   |                                |
| May 12 2012   |  |   |                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |                                |
| Dorothy Sevey MD 6934 Aviation Boulevard Ste #R Glen Burnie, MD   |  |   |                                |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature   |                                |
| MAY 15 2012   |  |   |                                |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

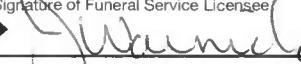
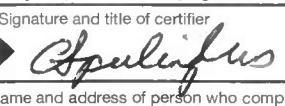
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15369

1- For  
State  
Registrar

|  |  |   |  |  |  |  |  |   |   |
|--|--|---|--|--|--|--|--|---|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EDWARD HEINLE</b>                                       |   |  |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>11</b> , Year <b>2012</b>  | 3. Time of Death<br><b>5:30 AM</b>  |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>GOOD SAMARITAN NURSING CENTER</b> |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |  | 4c. County of Death<br><b>MARYLAND</b>   |   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-05-5528</b>  | 6. Sex<br><b>1 X M 2 □ F</b>  | 7. Age (In yrs. last birthday)<br><b>92</b><br>Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days               | 8. Date of Birth<br>(Month, Day, Year)<br><b>1-25-1920</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   |   |
|  | Usual Residence of Decedent<br><b>MD.</b>  |   | 10a. State<br>10b. County<br><b>BALTIMORE</b>  |  |  |  | 10d. Inside City Limits<br><b>1 X Yes 2 □ No</b>   |   |   |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>305 JOPLIN STREET</b>   |   |  | 10f. Zip Code<br><b>21224</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|  | 11. Marital Status<br>1 □ Never Married 2 □ Married<br>3 X Widowed 4 □ Divorced                        |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 X Yes 2 □ No<br>If Yes, Give Year or Dates.<br><b>1943-1946</b> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 □ Yes 2 X No Specify:<br><b>WHITE</b> |   |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10TH</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>                |  |  | 16b. Kind of Business/Industry<br><b>BETHLEHEM STEEL</b>   |  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL HEINLE</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELIZABETH STOCK</b>                                      |  |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CELESTE CIECIERSKI</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>DTR. 2419 ARAPAHO WAY GAMBRILLS, MD. 21054</b> |  |  |  |  |   |   |
| 20a. Method of Disposition<br>1 X Burial 2 □ Cremation 3 □ Removal from State<br>4 □ Donation 5 □ Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SACRED HEART OF JESUS</b>   |  |  | Date<br><b>5-14-2012</b>                                   | 20c. Location - City or Town, State<br><b>DIUNDALK, MD.</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVENUE BALTO. MD. 21224</b>                                  |  |  |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   | Approximate Interval Between Onset and Death<br><b>metastatic squamous Cell Cancer of penis</b>  |  |  |  |  |   |   |
| b. Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |
| c. Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |
| d. Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 □ Yes 2 □ No 9 □ Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br>4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |  |  |  |  |  | 23d. Date of delivery<br>Month Day Year   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension, pulmonary embolism</b>  |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown |   |
| 25. Was case referred to medical examiner?<br>1 □ Yes 2 X No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)            |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 □ Yes 2 X No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 □ Yes 2 □ No |
| 27. Manner of Death<br>1 X Natural 5 □ Pending Investigation<br>2 □ Accident 6 □ Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 □ Yes 2 □ No | 28d. Describe how injury occurred                          |  |   |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |  |  |  |   |   |
| 29a. Certifier<br>(Check only one)<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/11/2012</b>   |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 28987</b>   |  |  |  |  |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CARL SPERLING M.D., 5601 LOON RAVEN BLVD BALTO, MD 21239</b>  |  |   |  |  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15370

1- For  
State  
Registrar

|  |   |  |   |   |  |                           |   |   |  |   |  |   |  |
|--|---|--|---|---|--|---------------------------|---|---|--|---|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Michael Joseph Harrington</b>  |  |   |   |  |                           | 2. Date of Death<br>Month <b>05</b> Day <b>10</b> Year <b>2012</b>  | 3. Time of Death<br><b>3:10A M</b>                            |  |   |  |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |  |                           | 4c. County of Death<br><b>Howard</b>  |   |  |   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-28-3355</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79 Yrs.</b>  |  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/03/1932</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |   |  |
|  | Usual Residence of Decedent<br><b>MD</b>  |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>   |                           | 10c. City, Town or Location<br><b>Linthicum</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>505 Southwell Road</b>   |  |   |   | 10f. Zip Code<br><b>21090</b>  |                           |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                |  |   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates                                  |  |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)<br/>12</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)<br/>Specialist<br/>Air Traffic Control</b> |  |                           | 16b. Kind of Business/Industry<br><b>BWI</b>  |   |  |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Harrington</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Charlotte Stubbs</b>   |                           |   |   |  |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Gretchen Harrington / Wife</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>505 Southwell Road Linthicum, MD 21090</b> |                           |   |   |  |   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>Selena Polley</i>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |  |                           | Date<br><b>05/12/2012</b>   | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b> |  |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>MO1479</b>  |  |   | 22. Name and Address of Facility<br><b>1 2nd Avenue SW Glen Burnie, MD<br/>Singleton Funeral &amp; Cremation Services, PA</b>   |  |                           |   |   |  |   |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |                           |   |   | Approximate Interval Between Onset and Death<br><b>DAYS</b>  |   |  |   |  |
|  | <p>a. <b>STROKE</b><br/>Due to (or as a consequence of):</p> <p>b. <b>END STAGE RENAL DISEASE</b><br/>Due to (or as a consequence of):</p> <p>c. <b>CORONARY ARTERY DISEASE</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |  |                           |   |   |  |   |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |                           |   |   | 23d. Date of delivery<br>Month Day Year  |   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>   |  |   |   |  |                           |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital:   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |                           | Other:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>HOSPICE</b>                                    |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural    5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident    6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide    4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   |                           | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |  |   |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |                           |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |   |  |                           |   |   |  |   |  |   |  |
|  | 29b. Signature and title of certifier<br><i>Danielle Doberman, MD</i>   |  | 29c. License number<br><b>D64395</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 10, 2012</b>   |                           |   |   |  |   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DANIELLE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, MD 21044</b>   |  |   |   |  |                           |   |   |  |   |  |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><i>Leanne J. Stuckel</i>   |   |  |                           |   |   |  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 2b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10x/  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15371

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

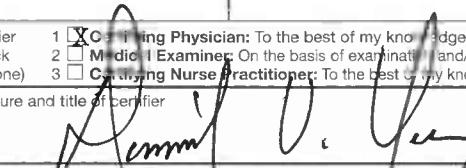
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director.

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>11:15 A M  |
| <b>Margaret Walker Hunt</b>  |  | May 9, 2012   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>5712 Cromwell Drive</b>   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |   | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br><b>577-16-2739</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>94 Yrs. | If Under 1 Year<br>Months Days Hours Min.  |
| Usual Residence of Decedent<br><b>Maryland</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>January 25, 1918</b>  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>5712 Cromwell Drive</b>   |  | 10f. Zip Code<br><b>20816</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>2</b>   |   | 16b. Kind of Business/Industry<br><b>Executive Secretary Education</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Myron R. Walker</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vitaline Pejean</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gregory Hunt / Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5712 Cromwell Drive, Bethesda, Maryland 20816</b>   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Montgomery Crematorium, Inc.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |   | Date<br><b>May 11, 2012</b>  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b><br><b>7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b>   |  | Approximate Interval Between Onset and Death Days   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last<br><b>Lung Cancer</b>  |  | Months  |   |  |
| c. <b>Dementia</b><br>Due to (or as a consequence of):   |  | Years   |   |  |
| d.   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>                    |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><b>Natural</b> <input checked="" type="checkbox"/><br><b>Accident</b> <input type="checkbox"/><br><b>Suicide</b> <input type="checkbox"/><br><b>Homicide</b> <input type="checkbox"/><br>5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M                  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Living Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Only one |  | 29c. License number<br><b>D25992</b>  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Daniel Young, M.D. 4530 Connecticut Avenue #104, Washington, D.C. 20008</b>   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15372

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth M. HALLAM

2. Date of Death

Month  
MAY

Day  
13

Year  
2012

3. Time of Death  
12:27 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

579-26-0147

6. Sex

M

2  F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Month

Day

Year

01/08/1928

12:27 AM

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

COCKEYSVILLE

10d. Inside City Limits

Yes  No

10e. Street and Number

9609 LABRADOR LANE

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married

3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

BIOCHEMIST

16b. Kind of Business Industry

ENVIRONMENTAL SCIENCE

17. Father's Name (First, Middle, Last)

JOSEPH HENRY

HALLAM

18. Mother's Name (First, Middle, Maiden Surname)

MARY

COHEN

19a. Informant's Name/Relationship (Type, Print)

JULIE HALLAM/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

324 QUAKER RIDGE ROAD, TIMONIUM, MD 21093

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL CONGR.

Date

20c. Location - City or Town, State

05/14/2012

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2-3 weeks

a. Congestive heart Failure

Due to (or as a consequence of):

b. Coronary Atherosclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

Bladder Cancer

Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:  
1  Inpatient 2  ER/Outpatient 3  DOA

Other:  
4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

D 0054717

29d. Date signed (Month, Day, Year)

05/13/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rameen Molavi, M.D. 10755 FALLS RD SUITE 200 LUTHERVILLE MD 21093

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15373

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |                  |     |      |                  |
|--|------------------|-----|------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death |     |      | 3. Time of Death |
| Joyce Ann Isaac                          | Month            | Day | Year | 6:19 AM          |
| May 10, 2012                             |                  |     |      |                  |

|  |                                      |  |  |                     |
|--|--------------------------------------|--|--|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death |  |  | 4c. County of Death |
| 3601 Blackstone St.  | Randallstown                         |  |  | Baltimore           |

Funeral  
Director

|                           |  |                                |                 |                  |                  |  |
|---------------------------|--|--------------------------------|-----------------|------------------|------------------|--|
| 5. Social Security Number | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) |
| 212-60-9314               | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 62 Yrs.                        | Months          | Days             | Month Day Year   | July 5, 1949 MD                          |

Usual Residence of Decedent  
10a. State  
MD  
10b. County  
Baltimore  
10c. City, Town or Location  
Randallstown  
10e. Street and Number  
3601 Blackstone St.  
10f. Zip Code  
21133  
10g. Citizen of What Country?  
USA

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Degree                                     |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse | 16b. Kind of Business Industry<br>Rosewood Hospital              |

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br>Robert Mitchell                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances Vaughn  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Valerie Boyd (cousin) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4211 Springwood Ave. Balto, Md. 21206 |

|   |   |                      |   |
|---|---|----------------------|---|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><i>Calvin B. Scruggs</i> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>WoodLawn Cemetery | Date<br>May 18, 2012 | 20c. Location - City or Town, State<br>Baltimore, Md. |
|---|---|----------------------|---|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensed<br><i>Calvin B. Scruggs</i> | 22. Name and Address of Facility<br>Calvin B. Scruggs Funeral Home<br>1412 E. Preston St. Balto, Md. 21213 |
|---|--|

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |   |   |
|--|---|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 23c. Approximate Interval Between Onset and Death |
| <p>a. <i>Sudden Cardiac Death</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Tachyarrhythmia</i><br/>Due to (or as a consequence of):</p> <p>c. <i>Left Ventricular Hypertrophy</i><br/>Due to (or as a consequence of):</p> <p>d. <i>Hypertension</i></p>            |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   | 23d. Date of delivery<br>Month Day Year           |

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dyslipidemia, Diabetes Mellitus</i> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|---|--|--|--|

|  |  |                     |  |  |
|--|--|---------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|   |  |                               |   |
|---|--|-------------------------------|---|
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier<br><i>Charles Moore MD</i> | 29c. License number<br>D35330 | 29d. Date signed (Month, Day, Year)<br>05/14/2012 |
|---|--|-------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Charles G. Moore MD</i> |
|--|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012 | 32. Registrar's Signature<br><i>Leanne D. Garcia</i> |
|--|--|

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15374

1 - For  
State  
Registrar

|  |  |   |   |   |   |  |  |   |  |
|--|--|---|---|---|---|--|--|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)   |   |   |   | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death<br>0630 AM  |   |  |
|  | William Alexander Jones Jr.  |   |   |   | May 10 2012   |  |  |   |  |
| Funeral<br>Director  | 4a. Facility Name (if not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death  |   |  |
|  | 5. Social Security Number<br><b>212-28-3735</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>01 08 26</b>                | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>3713 West Coldspring Lane</b>   |   | 10f. Zip Code<br><b>21215</b>   |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
| Physician/<br>Medical<br>Examiner  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>10th grade</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Pipe Fitter</b>                |   | 16b. Kind of Business/Industry<br><b>Beth Steel Corp.</b>   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Alexander Sr.</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elvira Dorsey</b>   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen B. Jones-Wife</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3713 West Coldspring Lane, Baltimore, Md 21215</b>                                |   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► Elvira Dorsey</b>  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet</b>  |   | Date   | 20c. Location - City or Town, State<br><b>5/18/2012 Owings Mills, Md</b> |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Elvira Dorsey</b>  |  |   |   | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, Md 21215</b>  |   |  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Aspiration Pneumonia</b>  |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1 day</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b>   |  |   |   |   |   |  |  |   |  |
| a. Due to (or as a consequence of):<br><b>Aspiration Pneumonia</b>   |  |   |   |   |   |  |  |   |  |
| b. Due to (or as a consequence of):  |  |   |   |   |   |  |  |   |  |
| c. Due to (or as a consequence of):  |  |   |   |   |   |  |  |   |  |
| d. Due to (or as a consequence of):  |  |   |   |   |   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |   |   |  |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe left ventricular hypertrophy</b><br><b>multiple sclerosis, hypertension</b>  |  |   |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>HOSPICE</b> |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)<br><b>28b. Time of injury<br/>M</b><br>28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>► K. C. Jones MD</b>  |   | 29c. License number<br><b>DE5 000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 10, 2012</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KATHLEEN OCTAVIEC SINAI HOSPITAL OF BALTIMORE Balt. MD 21215</b>  |  |   |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>► Jennifer D. Parker</b>  |   |   |   |  |  |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JONES JR. WILLIAM

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 8 per fh g927 5-17-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15375

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

William

Jones

2. Date of Death

Month

05

Day

Year

2012

3. Time of Death

4:00a.m

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-01-3735

6. Sex

M

F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

10

Day

Year

2012

4:00a.m

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

5717 Rubin Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)  
na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Operator

16b. Kind of Business Industry

Mass Transit Admin.

17. Father's Name (First, Middle, Last)

Willie Jones

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Sykes

19a. Informant's Name/Relationship (Type, Print)

Madeline Jones-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5717 Rubin Ave, Baltimore, Md 21215

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

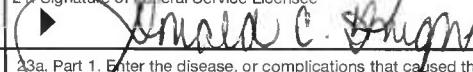
Date

5/21/2012

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

March F/H West  
4300 Wabash Ave, Baltimore, Md 21215

Approximate Interval Between Onset and Death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):  
*Dementia*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Aspiration Pneumonia*

*Dysphagia*

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

Inpatient  ER/Outpatient  DOA

Other:

Nursing Home  Residence  Other (Specify)

*Hospital*

27. Manner of Death

Natural  Pending Investigation  
 Accident  Determined  
 Suicide  Could not be determined  
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

Yes  No

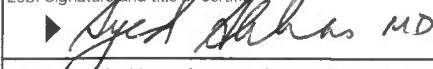
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

DE72139

29d. Date signed (Month, Day, Year)

May 11<sup>th</sup> 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*EDWARD Q. ABARS 6701 N Charles Street Suite 4105 Baltimore MD 21204*

31. Date filed (Month, Day, Year)

*MAY 15 2012*

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a Per FH G9275/23/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15376

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death  |  |
| <i>Joan Elizabeth Jackson</i>  |  | MAY 9th, 2012   |  | 12:10 PM  |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>Union Memorial Hosp.</i>  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death   |  |
| 5. Social Security Number<br><b>217-34-8849</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  |
| 8. If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  | 9. Date of Birth<br>(Month, Day, Year)<br><b>May 05, 1936</b>   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br><b>2702 N. Calvert Street</b>  |  | 10f. Zip Code<br><b>21218</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Machine Operator</b>   |  | 16b. Kind of Business/Industry<br><b>Kirk-Stieff Silversmith</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Raymond Hurley</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Addison Pearsall</b>  |  |   |  |
| 19. Child's Name (Relationship Type, Print)<br><b>Mildred McKenzie daughter</b><br><b>Mildred Collins / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1310 West 37th Street Baltimore, MD 21211</b>   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Date<br><b>May 12, 2012</b>   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b> |
| 21. Signature of Funeral Service Licensee<br><b>Lynnda Sue Ritter MO1443</b>   |  | 22. Name and address of Facility<br><b>Cremation and Funeral Alternatives</b><br><b>8717 Green Pastures Drive Towson Maryland 21286</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>1 week</b>   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |   |  |
| a. Due to (or as a consequence of):<br><b>ARDS</b>   |  |   |  |   |  |
| b. Due to (or as a consequence of):<br><b>multibular Pneumonia</b>   |  |   |  |   |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |  |
|  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Muhammed Jasareen, MD</b>  |  | 29c. License number<br><b>AT2438946-D8</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY, 9th, 2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MUHAMMED JASAREEN, 201 East University Parkway, Baltimore, MD 21218</b>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Sherman J. Parker</b>   |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2012 15377

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

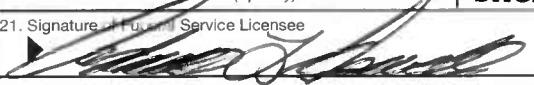
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
 within 24 hours after death.  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director; page 2 should be detached for use as the burial-transit

State  
Registrar

|  |             |   |   |  |  |                                     |  |
|--|-------------|---|---|--|--|-------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)   |             | 2. Date of Death  |   |  |  | 3. Time of Death                    |  |
| <b>FREDERICK JAMES</b>   |             | <b>May 10 2012</b>  |   |  |  | <b>93A M</b>                        |  |
| 4a. Facility Name (If not institution, give street and number)   |             | 4b. City, Town, or Location of Death  |   |  |  | 4c. County of Death                 |  |
| <b>RIVERVIEW REHAB &amp; HEALTH</b>  |             | <b>ESSEX</b>  |   |  |  | <b>BALTIMORE</b>                    |  |
| 5. Social Security Number  |             | 6. Sex  | 7. Age (In yrs. last birthday)  | If Under 1 Year  | If Under 24 Hrs.                         | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country)       |
| <b>216-16-6864</b>   |             | <b>1 X M 2 F</b>  | <b>88 Yrs.</b>  | Months   | Days                                     | <b>11/11/1923</b>                   | <b>MARYLAND</b>                                |
| Usual Residence of Decedent  |             |   |   |  |  |                                     |  |
| 10a. State   | 10b. County | 10c. City, Town or Location   |   |  |  | 10d. Inside City Limits             |  |
| <b>MD</b>  | <b>N/A</b>  | <b>BALTIMORE</b>  |   |  |  | <b>1 X Yes 2 No</b>                 |  |
| 10e. Street and Number   |             |   | 10f. Zip Code   |  |  | 10g. Citizen of What Country?       |  |
| <b>615 S. DECKER AVENUE</b>  |             |   | <b>21224</b>  |  |  | <b>U.S.A.</b>                       |  |
| 11. Marital Status   |             | 12. Was Decedent Ever in U.S. Armed Forces?   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |                                     | 14. Race - American Indian, Black, White, etc. |
| <b>1 X Never Married 2 F Married<br/>3 D Widowed 4 D Divorced</b>  |             | <b>1 X Yes 2 D No<br/>If Yes, Give Year or Dates: 1942-46</b>   |   | <b>1 D Yes 2 X No Specify:</b>   |  |                                     | <b>Specify: WHITE</b>                          |
| 15. Decedent's Education (Specify only highest grade completed)  |             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |  | 16b. Kind of Business/Industry      |  |
| <b>Elementary/Secondary (0-12) 9</b>   |             |   | <b>SHEETMETAL WORKER</b>  |  |  | <b>CO. LLOYD E. MITCHELL</b>        |  |
| 17. Father's Name (First, Middle, Last)  |             |   |   | 18. Mother's Name (First, Middle, Maiden Surname)  |  |                                     |  |
| <b>HENRY T. JAMES, SR.</b>   |             |   |   | <b>TRESA CREAMER</b>   |  |                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)   |             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |   |  |  |                                     |  |
| <b>PATRICIA JAMES/ SISTER</b>  |             | <b>615 S. DECKER AVENUE, BALTIMORE, MARYLAND 21224</b>  |   |  |  |                                     |  |
| 20a. Method of Disposition   |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | Date   | 20c. Location - City or Town, State      |                                     |  |
| <b>1 X Burial 2 D Cremation 3 D Removal from State<br/>4 D Donation 5 D Other (Specify)</b>  |             | <b>SACRED HEART OF JESUS</b>  |   | <b>5/14/12</b>   | <b>BALTIMORE, MD</b>                     |                                     |  |
| 21. Signature of Funeral Service Licensee  |             | 22. Name and Address of Facility  |   |  |  |                                     |  |
|   |             | <b>LILY &amp; ZEILER INC. FUNERAL HOME<br/>700 S. CONKLING STREET, BALTO., MD 21224</b>   |   |  |  |                                     |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |   |   |  |  |                                     |  |
| Immediate Cause (Final disease or condition resulting in death)  |             |   |   |  |  |                                     |  |
| a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  |             |   |   |  |  |                                     |  |
| b. _____ Due to (or as a consequence of):  |             |   |   |  |  |                                     |  |
| c. _____ Due to (or as a consequence of):  |             |   |   |  |  |                                     |  |
| d. _____   |             |   |   |  |  |                                     |  |
| Approximate Interval Between Onset and Death   |             |   |   |  |  |                                     |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |   |   |  |  |                                     |  |
| Immediate Cause (Final disease or condition resulting in death)  |             |   |   |  |  |                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |             |   |   |  |  |                                     |  |
| {  |             |   |   |  |  |                                     |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 D Yes 2 D No<br>9 D Unknown   |             | 23c. If yes, outcome of pregnancy<br>1 D Live Birth 2 D Fetal death 3 D Ectopic pregnancy<br>4 D Pregnant at time of death 5 D Other (Specify)<br>9 D Unknown |   |  |  |                                     |  |
| 23d. Date of delivery<br>Month Day Year  |             |   |   |  |  |                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |   |   |  |  |                                     |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 D Yes 2 D No 3 D Probably 4 X Unknown  |             |   |   |  |  |                                     |  |
| 23f. Was case referred to medical examiner?<br>1 D Yes 2 D No  |             | 23g. Place of Death (Check only one)<br>Hospital: 1 D Inpatient 2 D ER/Outpatient 3 D DOA Other: 4 D Nursing Home 5 D Residence 6 D Other (Specify)           |   |  |  |                                     |  |
| 27. Manner of Death<br>1 D Natural 5 D Pending Investigation<br>2 D Accident 6 D Could not be determined   |             | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury  | 28c. Injury at work?<br>M 1 D Yes 2 D No | 28d. Describe how injury occurred   |  |
|  |             |   |   |  |  |                                     |  |
|  |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                 |  |                                     |  |
| 29a. Certifier<br>(Check only one)<br>1 D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 D Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             |   |   |  |  |                                     |  |
| 29b. Signature and title of certifier<br>   |             | 29c. License number<br><b>015872</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 10 2012</b>  |  |                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |             |   |   |  |  |                                     |  |
| <b>Karen Bub 6938 Aviation Blvd Glen Burnie 21061</b>  |             |   |   |  |  |                                     |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |             | 32. Registrar's Signature<br>  |   |  |  |                                     |  |

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15378

1- For State  
Registrar**Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>2055 hrs |
| <b>Larry D. Johnson</b>                  | May 8, 2012                        |                              |

|  |  |                                   |
|--|--|-----------------------------------|
| 4a. Facility Name (if not institution, give street and number)<br><b>1 West Conway Street Apt. # 904</b> | 4b. City, Town, or Location of Death<br><b>Baltimore</b> | 4c. County of Death<br><b>N/A</b> |
|--|--|-----------------------------------|

**Funeral  
Director**

|   |                            |  |   |                                |  |   |
|---|----------------------------|--|---|--------------------------------|--|---|
| 5. Social Security Number<br><b>219-66-9491</b> | 6. Sex<br><b>1 X M 2 F</b> | 7. Age (In yrs. last birthday)<br><b>57 Yrs.</b> | If Under 1 Year<br>Months Days Hours Min. | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>07/07/1954</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|---|----------------------------|--|---|--------------------------------|--|---|

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, MD 21215-0036**

|                         |                           |   |  |
|-------------------------|---------------------------|---|--|
| 10a. State<br><b>MD</b> | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b> | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|-------------------------|---------------------------|---|--|

|   |                               |  |
|---|-------------------------------|--|
| 10e. Street and Number<br><b>1 W. Conway St. #904</b> | 10f. Zip Code<br><b>21201</b> | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|---|-------------------------------|--|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <b>Black</b> | 14. Race - American Indian, Black, White, etc. |
|--|---|--|--|

|  |  |   |
|--|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10th Grade</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b> | 16b. Kind of Business/Industry<br><b>Construction Co.</b> |
|--|--|---|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>James Johnson</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florene Williams</b> |
|---|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>April Johnson (Daughter)</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3032 Belmont Ave., Baltimore, MD 21216</b> |
|---|--|

|   |   |                         |   |
|---|---|-------------------------|---|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>D.B.</i> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cem</b> | Date<br><b>05/14/12</b> | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |
|---|---|-------------------------|---|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br><i>D.B.</i> | 22. Name and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home PA<br/>2140 N. Fulton Ave., Baltimore, MD 21217</b> |
|--|---|

**Physician  
/Medical  
Examiner**

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

|   |  |
|---|--|
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of): |  |
|---|--|

|  |  |
|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>c.<br>d. |  |
|--|--|

|                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED |
|-----------------------------------|----------------------------------|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Oral Cancer</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |   |
|---|---|
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|---|

|   |  |  |
|---|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|--|--|

|  |  |                     |  |   |
|--|--|---------------------|--|---|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred   |
|  |  |                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) |
|  |  |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)              |

|   |
|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

|  |  |  |
|--|--|--|
| 29b. Signature and title of certifier<br><i>J. Walter Reed</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b> |
|--|--|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><i>James A. Jones</i> |
|---|--|

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

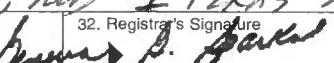
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15379

1- For  
State  
Registrar

|  |   |   |   |  |  |   |  |  |
|--|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>PATRINA KAHL</b>   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>10</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>348PM</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7832 Birmingham Avenue</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Parkville</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-36-9124</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73 Yrs.</b>  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct. 1, 1938</b>           | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Baltimore</b>  |   |   | 10c. City, Town or Location<br><b>Parkville</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>7832 Birmingham Avenue</b>   |   |   | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  | 16b. Kind of Business/Industry<br><b>Christian School</b>                        |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Sebastian N. Sessa</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Messina</b>   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Kahl, Jr- Son</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Yew Court-Baltimore, Maryland 21221</b>  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>May 15, 2012</b>  | 20c. Location - City or Town, State<br><b>Parkville, Maryland</b>       |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Connie L. McFadden</b>  |   | 22. Name and Address of Facility<br><b>Evans Funeral Chapel and Cremation Services<br/>8800 Harford Road-Parkville, Maryland 21234</b>  |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |   |   | Approximate Interval Between Onset and Death<br><b>4 YEARS</b>   |  |   |  |  |
|  | a. <b>ENDOMETRIAL CANCER</b><br>Due to (or as a consequence of):  |   |   |  |  |   |  |  |
|  | b. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |  |  |
|  | c. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |  |  |
|  | d. _____  |   |   |  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION, HYPERLIPIDEMIA,<br/>ANXIETY/DEPRESSION</b>   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |
|  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |
|  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |  |  |   |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of Injury<br>(Month, Day, Year)   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred                                       |  |  |
|  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |  |  |
|  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>053095</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 11, 2012</b>                       |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eric J. Carr, MD 9 Texas Station Ct #210 Timonium, MD 21093</b>  |   |   |  |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   | 32. Registrar's Signature<br>  |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15380

1 - For  
State  
Registrar

|                                     |   |   |   |   |  |  |   |   |  |  |
|-------------------------------------|---|---|---|---|--|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS STANLEY KYZOUR</b>  |   |   |   |  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>     | 3. Time of Death<br>2:01P M  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>Stella Maris</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |  |   | 4c. County of Death<br><b>Baltimore</b>                                 |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>212-20-0786</b><br>Usual Residence of Decedent  | 6. Sex<br><b>1 XX M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/14/1924</b>                        | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Timonium</b>  |   |  |  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                            |  |  |
|                                     | 10e. Street and Number<br><b>2300 Dulaney Valley Road</b>   |   |   |   | 10f. Zip Code<br><b>21093</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|                                     | 11. Marital Status<br><b>XX Never Married 2 Married<br/>3 Widowed 4 Divorced</b>  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br><b>XX Yes 2 No</b> Korea<br>If Yes, Give Year or Dates. |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:<br><b>XX</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Manager</b>               |  |  | 16b. Kind of Business/Industry<br><b>Railroad</b>           |   |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Charles Francis Kyzour</b>  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Catherine Slechta</b> |   |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph E Hickey</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1911 Corbridge Lane Monkton, Maryland 21111</b> |  |  |   |   |  |  |
|                                     | 20a. Method of Disposition<br><b>XX Burial 2 Cremation 3 Removal from State<br/>4 Donation 5 Other (Specify)</b>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer Cemetery</b>  |  |  | Date<br><b>05/16/2012</b>                                   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Thomas Stanley Kyzour</i>   |   |   | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home Inc<br/>6500 York Road Baltimore, Maryland 21212</b>                         |  |  |   |   |  |  |
| Physician/<br>Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |   |   |   |  |  |   |   | Approximate Interval Between Onset and Death   |  |
|                                     | a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):  |   |   |   |  |  |   |   |  |  |
|                                     | b. _____<br>Due to (or as a consequence of):  |   |   |   |  |  |   |   |  |  |
|                                     | c. _____<br>Due to (or as a consequence of):  |   |   |   |  |  |   |   |  |  |
|                                     | d. _____  |   |   |   |  |  |   |   |  |  |
|                                     | IF FEMALE:  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |  |  |   |   | 23d. Date of delivery<br>Month Day Year  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |  |
|                                     |   |   |   |   |  |  |   |   | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |
|                                     | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   | Hospital: _____   |   | 26. Place of Death (Check only one)<br><b>1 Inpatient 2 ER/Outpatient 3 DOA<br/>4 Nursing Home 5 Residence 6 Other (Specify) <b>HOSPICE</b></b>            |  |   |   |  |  |
|                                     | 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide<br/>4 Homicide</b>   |   | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 Yes 2 No</b>  | 28d. Describe how injury occurred                           |   |  |  |
|                                     |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   | 29c. License number<br><b>B149792</b>   |   |  |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |   |   |   |  |  |   |   |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   | 32. Registrar's Signature<br><i>James A. Jones</i>  |   |  |  |   |   |  |  |

MAY 13, 2012 2:01 p.m.

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

THOMAS KYZOUR  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No.

2012 1538

|   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
|---|-------------|--|---|--|---|--|------------------|--|--|---|---|--|--|
| For<br>State<br>Registrar   |             | State of Maryland / Department of Health and Mental Hygiene  |   | Certificate of Death   |   | Reg. No.   | 2012             | 1538   |  |   |   |  |  |
| 1. Decedent's Name (First, Middle, Last)  |             |  |   |  |   | 2. Date of Death   |                  | 3. Time of Death                               |  |   |   |  |  |
| Stanley Thomas Krausman   |             |  |   |  |   | Month<br>May   |                  | Day<br>12, 2012                                |  |   |   |  |  |
| 4a. Facility Name (if not institution, give street and number)  |             |  |   |  |   | 4b. City, Town, or Location of Death   |                  | 4c. County of Death                            |  |   |   |  |  |
| Gilchrist Hospice   |             |  |   |  |   | Columbia   |                  | Howard   |  |   |   |  |  |
| 5. Social Security Number   |             | 6. Sex   | 7. Age (In yrs. last birthday)  | If Under 1 Year  |   | If Under 24 Hrs.   |                  | 8. Date of Birth (Month, Day, Year)            |  | 9. Birthplace (State or Foreign Country)            |   |  |  |
| 214-44-7836   |             | <input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 66 Yrs.   | Months   | Days  | Hours  | Min.             | 02/03/1945                                     |  | Maryland  |   |  |  |
| Usual Residence of Decedent   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 10a. State  | 10b. County |  | 10c. City, Town or Location   |  |   |  |                  |  |  |   | 10d. Inside City Limits   |  |  |
| WV  | Greenbrier  |  | Lewisburg   |  |   |  |                  |  |  |   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number  |             |  |   |  |   | 10f. Zip Code  |                  |  |  | 10g. Citizen of What Country?                       |   |  |  |
| Route 2 Box 279 Ridgedale Road  |             |  |   |  |   | 24901  |                  |  |  | U.S.A.  |   |  |  |
| 11. Marital Status  |             | 12. Was Decedent Ever in U.S. Armed Forces?  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |                  | 14. Race - American Indian, Black, White, etc. |  |   |   |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |             | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:                           |  |                  | Specify:<br>White                              |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)   |             |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |   | 16b. Kind of Business/Industry   |                  |  |  |   |   |  |  |
| Elementary/Secondary (0-12)   |             | College (1-4 or 5+)  |   | 2  |   |  | Carpet Installer |  |  | Flooring  |   |  |  |
| 17. Father's Name (First, Middle, Last)   |             |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)                                    |                  |  |  |   |   |  |  |
| Joseph Anthony Krausman   |             |  |   |  |   | Sonya Elizabeth Mellon   |                  |  |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)  |             |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)            |   |  |                  |  |  |   |   |  |  |
| Timothy Krausman / Son  |             |  |   | RR2 Box 274C, Lewisburg, WV 24901  |   |  |                  |  |  |   |   |  |  |
| 20a. Method of Disposition  |             |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                    |  |   | Date   |                  | 20c. Location - City or Town, State            |  |   |   |  |  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |             |  | Anatomy Gifts Registry  |  |   | 05/15/2012   |                  | Hanover, Maryland                              |  |   |   |  |  |
| 21. Signature of Funeral Service Licensee   |             |  |   | 22. Name and Address of Facility Anatomy Gifts Registry<br>7522 Connelley Dr., Ste. P, Hanover, MD 21076 |   |  |                  |  |  |   |   |  |  |
| 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br>MARCH 2011  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>COLON CANCER   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE |   |  |   |  |                  |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |             | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                  | 28d. Describe how injury occurred              |  |   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |             |  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                  |  |  |   |   |  |  |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><br>DANIELLE DOBERMAN, MD  |             |  |   |  |   | 29c. License number<br>D64395  |                  |  |  | 29d. Date signed (Month, Day, Year)<br>MAY 14, 2012 |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DANIELLE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, MD 21044  |             |  |   |  |   |  |                  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012  |             |  | 32. Registrar's Signature<br>S. J. Gause  |  |   |  |                  |  |  |   |   |  |  |

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15382

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gwendolyn A. Kelso

2. Date of Death

Month Day Year  
May 10, 2012

3. Time of Death

12:20 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

707 Kerwin Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-48-3514

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

Yrs.

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 5, 1935

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Deceased

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

707 Kerwin Road

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Silver Appraiser

16b. Kind of Business/Industry

Appraiser

17. Father's Name (First, Middle, Last)

(unk)

(unk)

18. Mother's Name (First, Middle, Maiden Surname)

(unk)

19a. Informant's Name/Relationship (Type, Print)

Andrea J. Sloan / Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1350 Beverly Rd. #115-123 McLean, VA 22101

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 05/12/12

Date

20c. Location - City or Town, State

Woodbine, Maryland

21. Signature of Funeral Service Licensee



MO1251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784  
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death years

a. Dementia

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy

4  Pregnant at time of death 5  Other (specify)

9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural

5  Pending

Investigation

2  Accident

6  Could not be

3  Suicide

determined

4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only one)

3  Certifying Nurse Practitioner

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3  Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15383

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |
|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Agnes V. Kroner</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>12</b> Year <b>2012</b>  |  | 3. Time of Death<br>4: 12A M  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1816 Winans Avenue</b>  |  | 4b. City, Town, or Location of Death<br><b>Halethorpe</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |
| 5. Social Security Number<br><b>219-22-3593</b>  |  | 6. Sex<br><b>M</b>   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months      Days      Hours      Min.                                |
| Usual Residence of Decedent  |  |  |  |   |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Halethorpe</b>   |  |   |
| 10e. Street and Number<br><b>1816 Winans Avenue</b>  |  | 10f. Zip Code<br><b>21227</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 □ Never Married 2 XX Married</b><br><b>3 □ Widowed 4 □ Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 XX No</b><br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 XX No</b> Specify:<br><b>White</b>                       |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                 |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 0</b>   |  | 16b. Kind of Business/Industry<br><b>Bank Teller Banking</b>                            |
| 17. Father's Name (First, Middle, Last)<br><b>Herman J. Jones</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Evonne Jones</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniell Sainato / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1241 Oakland Terrace Road Arbutus, MD 21227</b>                                      |  |   |
| 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State</b><br><b>4 □ Donation 5 □ Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cem.</b>  |  | Date<br><b>May 15, 2012</b> 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |
| 21. Signature of Funeral Service Licensee<br><b>Allen C. Knowlton</b>  |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home , Inc.</b><br><b>1328 Sulphur Spring Road Arbutus, MD 21227</b>  |  |   |
| <p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{ a. <b>Cancer of uterus</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p> |  |  |  |   |
| <p>Approximate Interval Between Onset and Death<br/><b>2 years</b></p>   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 XX No</b><br><b>9 □ Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death</b><br><b>4 □ Pregnant at time of death 9 □ Unknown</b><br><b>3 □ Ectopic pregnancy 5 □ Other (specify) _____</b> |  | 23d. Date of delivery<br>Month Day Year   |
| <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death?<br/><b>1 □ Yes 2 XX No 3 □ Probably 4 □ Unknown</b></p>  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 XX No</b>   |  | <p>26. Place of Death (Check only one)<br/>Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DDA</b> Other: <b>4 □ Nursing Home 5 XX Residence 6 □ Other (Specify)</b></p>                |  |   |
| 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation</b><br><b>2 XX Accident 6 □ Could not be determined</b><br><b>3 □ Suicide 4 □ Homicide</b>   |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>May</b>  | 28b. Time of injury<br><b>M</b>                  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  | 28d. Describe how injury occurred   |
| 29a. Certifier<br>(Check only one)<br><b>1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  | 29b. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Carole B. Miller 900 Caton Ave Baltimore MD 21229</b>  |  |   |
| 29b. Signature and title of certifier<br><b>Carole B. Miller</b>   |  | 29c. License number<br><b>D35254</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-14-2012</b>                                 |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Allen C. Knowlton</b>  |  |   |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 1538+

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

George Lawson  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|   |  |   |   |  |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Month Day Year   |
| George Lawson   |  | May 12, 2012  |   | 2025 p M   |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |
| Maryland General Hospital   |  | Baltimore City  |   | N/A  |
| 5. Social Security Number   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>72 Yrs.   | 8. If Under 24 Hrs.<br>Months Days Hours Min.                                    |
| 226-52-7255   |  |   |   |  |
| 9. Birthplace (State or Foreign Country)  |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| Virginia  |  |   |   |  |
| 10a. State<br>Maryland  |  | 10b. County<br>N/A  | 10c. City, Town or Location<br>Baltimore  |  |
| 10e. Street and Number<br>805 Hartem Ave.   |  | 10f. Zip Code<br>21201  |   | 10g. Citizen of What Country?<br>USA   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates,   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)   | 16b. Kind of Business Industry<br>Barber<br>self-employed   |  |
| 17. Father's Name (First, Middle, Last)<br>George Lawson  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Henwood Annie Howard   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>George D. Lawson - son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>520 Little Margaret Lane Highland Springs, VA 23075  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory   | Date<br>5/15/12   | 20c. Location - City or Town, State<br>Catarsville, Maryland                     |
| 21. Signature of Funeral Service Licensee<br>▶ Kevin Parker   |  | 22. Name and Address of Facility<br>Parker Funeral Home, P.A. 21229<br>3512 Frederick Ave Baltimore, Maryland   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br>Non ST Segment Elevated Myocardial Infarction   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |
| a. Due to (or as a consequence of):<br>Pulmonary Edema  |  |   |   |  |
| b. Due to (or as a consequence of):<br>Coronary Artery Disease  |  |   |   |  |
| c. Due to (or as a consequence of):   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |
|   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28d. Describe how injury occurred   |  |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> only one<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29b. Signature and title of certifier<br>▶ Rama Vunnam.   |  | 29c. License number<br>89670  |   | 29d. Date signed (Month, Day, Year)<br>5/12/2012                                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Rama Vunnam, M.D., F.A.C.P. Maryland General Hospital   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012  |  | 32. Registrar's Signature<br>Leanna S. Parker   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15385

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |                           |   |  |  |  |   |  |
|--|---------------------------|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)   |                           | 2. Date of Death<br>Month Day Year  |  |  | 3. Time of Death   |   |  |
| Elsie Jubi Lee   |                           | May 7, 2012   |  |  | 6:15 P.M.  |   |  |
| 4a. Facility Name (if not institution, give street and number)   |                           | 4b. City, Town, or Location of Death  |  |  | 4c. County of Death  |   |  |
| 555 Elmcroft Blvd., Apt. #11302  |                           | Rockville   |  |  | Montgomery   |   |  |
| 5. Social Security Number n/a  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>0 Yrs.   | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>0 10   | 8. Date of Birth<br>(Month, Day, Year)<br>April 27, 2012  | 9. Birthplace (State or Foreign Country)<br>Maryland |
| Usual Residence of Decedent  |                           |   |  |  |  |   |  |
| 10a. State<br>Maryland   | 10b. County<br>Montgomery | 10c. City, Town or Location<br>Rockville  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> 2 <input type="checkbox"/> No  |   |  |
| 10e. Street and Number<br>555 Elmcroft Blvd., Apt. #11302  |                           | 10f. Zip Code<br>20850  |  |  | 10g. Citizen of What Country?<br>United States   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0  |                           | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Not Applicable  |  |  | 16b. Kind of Business/Industry<br>Not Applicable   |   |  |
| 17. Father's Name (First, Middle, Last)<br>Chad Lee  |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sara Sevey   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Chad Lee / Father  |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>555 Elmcroft Blvd., Apt.#11302, Rockville, MD 20850  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Panaca City Cemetery  |  |  | Date<br>May 12, 2012   | 20c. Location - City or Town, State<br>Panaca, Nevada   |  |
| 21. Signature of Funeral Service Licensee<br>► [Signature]   |                           | 22. Name and Address of Facility<br>M00896 Robert A. Pumphrey Funeral Home/Rockville, Inc.<br>300 W. Montgomery Ave., Rockville, MD 20850-2805  |  |  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                           | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)                |  |  | Approximate Interval Between Onset and Death   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |                           | a. Due to (or as a consequence of):<br>Edward's Syndrome  |  |  |  |   |  |
|  |                           | b. Due to (or as a consequence of):   |  |  |  |   |  |
|  |                           | c. Due to (or as a consequence of):   |  |  |  |   |  |
|  |                           | d. Due to (or as a consequence of):   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                           | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                           |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |                           |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |                           | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |  |
|  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                           |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>► [Signature]   |                           | 29c. License number<br>D37142   |  |  | 29d. Date signed (Month, Day, Year)<br>May 8, 2012   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Geoffrey Coleman, M.D., 1355 Piccard Dr., Suite 100, Rockville, Maryland 20850   |                           |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |                           | 32. Registrar's Signature<br>[Signature]  |  |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15386

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

|  |  |   |  |   |  |  |  |   |   |  |
|--|--|---|--|---|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DEBORAH LeWINN LONDON</b>   |  |   | 2. Date of Death<br>Month <b>05</b> Day <b>11</b> Year <b>2012</b>   |   |  | 3. Time of Death<br><b>13:01 PM</b>  |  |   |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>St Agnes hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   |  | 4c. County of Death<br><b>N/A</b>  |  |   |   |  |
| 5. Social Security Number<br><b>187-28-9298</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> |  | 7. Age (In yrs. last birthday)<br><b>78 Yrs.</b>  |  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>   |  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>      |   |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>11/18/1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                 |  |   |  |  |  |   |   |  |
| 10a. State<br><b>MD</b>  |  |   | 10b. County<br><b>BALTIMORE</b>  |   |  | 10c. City, Town or Location<br><b>CATONSVILLE</b>  |  |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |
| 10e. Street and Number<br><b>707 MAIDEN CHOICE LANE, #7301</b>   |  |   |  | 10f. Zip Code<br><b>21228</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>           |   |  |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b><br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates. |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>ARTIST</b>                               |  |  |  | 16b. Kind of Business Industry<br><b>ILLUSTRATION</b> |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD B. LeWINN</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PEARL FREEDMAN</b>  |  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PHILIP LONDON/HUSBAND</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>707 MAIDEN CHOICE LANE, #7301 CATONSVILLE, MD 21228</b> |  |  |  |   |   |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HILLCREST MEMORIAL GARDENS</b>   |  |  |  | Date<br><b>05/14/2012</b>                             | 20c. Location - City or Town, State<br><b>ANNAPOLIS, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Scott M. Gitter</b>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>                            |  |  |  |   |   |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|   |  |   |  |                                      |  |   |  |  |  |
|---|--|---|--|--------------------------------------|--|---|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   | Pseudomonas Pneumonia  |                                      |  | Approximate Interval Between Onset and Death<br><b>7 days</b>   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |                                      |  |   |  |  |  |
| a. Due to (or as a consequence of):   |  |   |  |                                      |  |   |  |  |  |
| b. Due to (or as a consequence of):   |  |   |  |                                      |  |   |  |  |  |
| c. Due to (or as a consequence of):   |  |   |  |                                      |  |   |  |  |  |
| d. Due to (or as a consequence of):   |  |   |  |                                      |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>9 <input type="checkbox"/> Unknown   |  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b><br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                      |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |                                      |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |  |  |
|   |  |   |  |                                      |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  |  |
|   |  |   |  |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |                                      |  |   |  |  |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b><br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury                  |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  | 28d. Describe how injury occurred  |  |
|   |  | <b>M</b>  |  |                                      |  |   |  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                      |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |  |                                      |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>► S. Bishow</b>   |  | MD  |  | 29c. License number<br><b>p25482</b> |  | 29d. Date signed (Month, Day, Year)<br><b>05.11.2012</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bishow C. Shrestha 900 S. Caton Ave., MD, 21229</b>  |  |   |  |                                      |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne B. Parker</b>  |  |                                      |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15387

Reg. No.

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

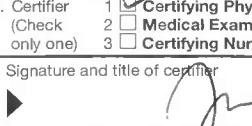
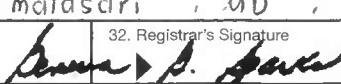
Baltimore, Maryland 21215-0036  
  
Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 05 Day 12 Year 12 30 AM   |   |   |  | 3. Time of Death<br>11:30 AM   |  |
| CLYDE O MOSES  |  |   |   |   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>Good Samaritan Hospital  |  | 4b. City, Town, or Location of Death<br>Baltimore, MD   |   |   |  | 4c. County of Death  |  |
| 5. Social Security Number<br>229-36-6478   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br>08/15/32   | 9. Birthplace (State or Foreign Country)<br>Virginia             |
| Usual Residence of Decedent<br>Maryland  |  | 10c. City, Town or Location<br>Baltimore  |   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>4708 Alhambra Avenue   |  | 10f. Zip Code<br>21212  |   |   |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th grade   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Custodian  |   | 16b. Kind of Business/Industry<br>Federal Government  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Horace Moses Jr.  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucy B. Trotter  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Constance L. Moses   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4708 Alhambra Ave. Baltimore, Maryland 21212   |   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Vet. Cemetery   |   | 20c. Location - City or Town, State<br>Owings Mills, Md.  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Chatman-Harris Funeral Home<br>4210 Belair Rd. Baltimore, Md. 21206   |   |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Myocardial ischemia  |   |   |  | Approximate Interval Between Onset and Death hours   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | a. Due to (or as a consequence of):<br>Heart Failure  |   |   |  | hours  |  |
| {  |  | b. Due to (or as a consequence of):<br>Accelerated severe Hypertension  |   |   |  | hours  |  |
| d.   |  | c. Due to (or as a consequence of):<br>Renal dysfunction  |   |   |  | hours  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>RES 000  |   |   |  | 29d. Date signed (Month, Day, Year)<br>05, 12, 2012  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>OLIVIA Nirmalasari, MD; Baltimore, MD  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>  |   |   |  |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15388

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(H)

State  
Registrar

|  |  |   |  |   |   |   |   |
|--|--|---|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  |   |   | 3. Time of Death<br>1228 PM   |   |
| <i>Justin Malone</i>   |  | 05 / 04 / 2012  |  |   |   |   |   |
| 4a. Facility Name (if not institution, give street and number)<br><i>Shock Trauma Center</i>   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  |   |   | 4c. County of Death   |   |
| 5. Social Security Number<br><b>212-17-9665</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>25</b><br>Yrs.  | If Under 1 Year<br>Months Days Hours Min.   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug. 1, 1986</b>           | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Parkville</b>  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |
| 10e. Street and Number<br><b>2 Skylar Court Apt. D</b>   |  |   | 10f. Zip Code<br><b>21234</b>  | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                       |   |   | 16b. Kind of Business/Industry<br><b>Construction</b>                   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Troy Andrade</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kelly Malone</b>  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul Coughlin/Stepfather</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44 N. Captains Dr. Little Egg Harbor, NJ 08087</b> |   |   |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>   |   | Date<br><b>05/07/12</b>   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |   |
| 21. Signature of Funeral Service Licensee<br><i>Christina Bas</i>  |  |   | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex 300 Mace Ave, Balto, MD 21221</b>  |   |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |   |   |   |   |
| <p>a. <i>Multiple Injuries</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Rolling</i><br/>Due to (or as a consequence of):</p> <p>c. <i>Rolling</i><br/>Due to (or as a consequence of):</p> <p>d. _____</p> <p style="text-align: right;">Approximate Interval Between Onset and Death</p>   |  |   |  |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |   |   | 23d. Date of delivery<br>Month Day Year                                 |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   |   |
| <p>23e. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>  |  |   |  |   |   |   |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |  |   |   |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>5/14/2012</b>   |  | 28b. Time of injury<br><b>6:15 AM</b>   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Motor Vehicle Accident</b>      |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Delaney Valley Rd &amp; Jarrettsville Pike</b>   |  |   |   |   |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |   |   |
| 29b. Signature and title of certifier<br><i>Melissa Rice, MD</i>   |  | 29c. License number<br><b>AU41764352100733</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>   |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Melissa Rice, MD 22 South Greene St Baltimore MD 21201</b>  |  |   |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b>  |  | 32. Registrar's signature<br><i>Renata B. Sparta</i>  |  |   |   |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 10a, 16a, per fh, g927 5-15-12 sm

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15389

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

MCINTYRE, DIANE'S

Division of Vital Records, P.O. Box 68760

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |                          |  |  |  |  |  |   |                              |
|--|--------------------------|--|--|--|--|--|---|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Diane McIntyre</b>  |                          |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 05, 2012</b>         | 3. Time of Death<br>10:45 AM |
| 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Hospital</b>  |                          |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  |  | 4c. County of Death<br><b>Montgomery</b>                          |                              |
| 5. Social Security Number<br><b>579-80-3077</b>  |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/18/1955</b>   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b> |                              |
| 10a. State<br><b>DE</b>  | 10b. County<br><b>MD</b> | 10c. City, Town or Location<br><b>Germantown</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                              |
| 10e. Street and Number<br><b>18525 Tarrong Way</b>   |                          |  |  | 10f. Zip Code<br><b>20874</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>4 years</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>Black</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |   |                              |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |                          |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |   |                              |
| 17. Father's Name (First, Middle, Last)<br><b>John Abney</b>   |                          |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Beaves</b>  |  |  |   |                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Pamela Love - daughter</b>  |                          |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16410 Woodley Road, Clinton, MD 20735</b>  |  |  |   |                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Harmony Memorial</b>   |                          |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial</b>  |  | Date<br><b>5/14/12</b>   | 20c. Location - City or Town, State<br><b>Landover, MD</b>        |                              |
| 21. Signature of Funeral Service Licensee<br><b>► Freeman</b>  |                          |  |  | 22. Name and Address of Facility<br><b>FREEMAN FUNERAL SERVICES<br/>4594 Beach Road, Temple Hills, MD 20785</b>  |  |  |   |                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                          |  |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |  |  |   |                              |
| a. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br><b>cardiac dysrhythmia</b>  |                          |  |  | <b>minutes</b>   |  |  |   |                              |
| b. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br><b>coronary artery disease</b>   |                          |  |  | <b>days</b>  |  |  |   |                              |
| c. <b>coronary artery disease</b><br>Due to (or as a consequence of):<br><b>years</b>  |                          |  |  |  |  |  |   |                              |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                          | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                          |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |                              |
|  |                          |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |
|  |                          |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |                          | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury                              | 28c. Injury at work?<br>M<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred  |  |   |                              |
|  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                              |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                          | 29c. License number<br><b>00062796</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>05/05/2012</b>   |   |                              |
| 29b. Signature and title of certifier<br><b>► Physician</b>  |                          |  |  |  |  |  |   |                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James McQuiston, MD 9901 Medical Center Drive, Rockville, Maryland 20850</b>  |                          |  |  |  |  |  |   |                              |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |                          | 32. Registrar's Signature<br><b>J. Parker</b>  |  |  |  |  |   |                              |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

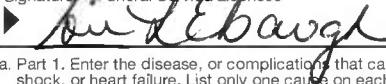
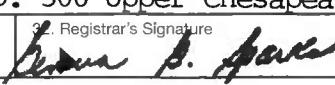
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15390

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|   |  |   |  |  |  |  |  |  |  |   |  |           |  |
|---|--|---|--|--|--|--|--|--|--|---|--|-----------|--|
|   |  | 1. Decedent's Name (First, Middle, Last)  |  |  |  | 2. Date of Death   |  | 3. Time of Death   |  |   |  |           |  |
|   |  | Henry E. Mattiello  |  |  |  | Month Day Year   |  | May 13 2012 8:14 A.M.  |  |   |  |           |  |
|   |  | 4a. Facility Name (if not institution, give street and number)  |  |  |  | 4b. City, Town, or Location of Death   |  |  |  |   |  |           |  |
|   |  | Upper Chesapeake Medical Center   |  |  |  | Bel Air  |  |  |  |   |  |           |  |
|   |  | 4c. County of Death   |  | Harford  |  |  |  |  |  |   |  |           |  |
| Funeral Director                          |  | 5. Social Security Number   |  | 6. Sex   |  | 7. Age (In yrs. last birthday)   |  | If Under 1 Year  |  |   |  |           |  |
|   |  | 141-20-2218   |  | 1 XM 2 F   |  | 84 Yrs.  |  | Months Days Hours Min.   |  |   |  |           |  |
|   |  | Usual Residence of Decedent   |  |  |  |  |  |  |  |   |  |           |  |
|   |  | 10a. State  |  | 10b. County  |  | 10c. City, Town or Location  |  |  |  | 10d. Inside City Limits   |  |           |  |
|   |  | Maryland  |  | Harford  |  | Edgewood   |  |  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |           |  |
|   |  | 10e. Street and Number  |  |  |  | 10f. Zip Code  |  |  |  | 10g. Citizen of What Country?   |  |           |  |
|   |  | 2222 Perry Avenue   |  |  |  | 21040  |  |  |  | United States   |  |           |  |
|   |  | 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)                                  |  | 14. Race - American Indian, Black, White, etc.                               |  |   |  |           |  |
|   |  | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 1945-1972  |  | Specify: White   |  |   |  |           |  |
|   |  | 15. Decedent's Education (Specify only highest grade completed)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)                                      |  |  |  | 16b. Kind of Business/Industry  |  |           |  |
|   |  | Elementary/Secondary (0-12)<br>12   |  |  |  | Chief Warrant Officer  |  |  |  | United States Army  |  |           |  |
|   |  | 17. Father's Name (First, Middle, Last)   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |  |  |   |  |           |  |
|   |  | Bruno Joseph Mattiello  |  |  |  | Susan M. Heitzman  |  |  |  |   |  |           |  |
|   |  | 19a. Informant's Name/Relationship (Type, Print)  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |           |  |
|   |  | Rosemary Goode / Daughter   |  |  |  | 2331 Gibson Road Forest Hill, Maryland 21050   |  |  |  |   |  |           |  |
|   |  | 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date   |  | 20c. Location - City or Town, State  |  |   |  |           |  |
|   |  | 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | Evans Funeral Chapel<br>Bel Air  |  | May 14, 2012   |  | Forest Hill, Maryland  |  |   |  |           |  |
|   |  | 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility   |  |  |  |  |  |   |  |           |  |
|   |  |   |  | Evans Funeral Chapel & Cremation Service-BelAir<br>3 Newport Drive Forest Hill, Maryland 21050   |  |  |  |  |  |   |  |           |  |
| Physician/<br>Medical<br>Examiner         |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.         |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |   |  |           |  |
|   |  | Immediate Cause (Final disease or condition resulting in death)   |  |  |  | Aspiration Pneumonia   |  |  |  | 1 week  |  |           |  |
|   |  | a. Due to (or as a consequence of):   |  |  |  |  |  |  |  |   |  |           |  |
|   |  | b. Due to (or as a consequence of):   |  |  |  |  |  |  |  |   |  |           |  |
|   |  | c. Due to (or as a consequence of):   |  |  |  |  |  |  |  |   |  |           |  |
|   |  | d. _____  |  |  |  |  |  |  |  |   |  |           |  |
| Physician/<br>Medical<br>Examiner         |  | IF FEMALE:  |  | 23c. If yes, outcome of pregnancy  |  |  |  | 23d. Date of delivery  |  |   |  |           |  |
|   |  | 23b. Was decedent pregnant in the past 12 months?   |  | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | Month Day Year   |  |   |  |           |  |
|   |  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>g <input type="checkbox"/> Unknown  |  |  |  |  |  |  |  |   |  |           |  |
|   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?   |  |  |  |   |  |           |  |
|   |  |   |  |  |  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |   |  |           |  |
|   |  | 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)  |  |  |  | 23f. Were autopsy findings available prior to completion of cause of death?  |  |   |  |           |  |
|   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)     |  |  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No      |  |   |  |           |  |
|   |  | 27. Manner of Death   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury  |  | 28c. Injury at work?   |  | 28d. Describe how injury occurred                                       |  |           |  |
|   |  | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined                          |  |  |  | M  |  | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                 |  |   |  |           |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |           |  |
|   |  | 29a. Certifier  |  | 29c. License number  |  |  |  | 29d. Date signed (Month, Day, Year)  |  |   |  |           |  |
|   |  | 1 <input type="checkbox"/> Medical Examiner<br>2 <input type="checkbox"/> Certifying Physician<br>3 <input type="checkbox"/> Certifying Nurse Practitioner  |  |  |  |  |  | D0086296   |  |   |  | 5-13-2012 |  |
|   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |  |  |  |  |  |  |   |  |           |  |
|   |  | Jason Birnbaum, M.D. 500 Upper Chesapeake Way Bel Air, Maryland 21014   |  |  |  |  |  |  |  |   |  |           |  |
| Division of Vital Records, P.O. Box 68760 |  | 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature  |  |  |  |  |  |   |  |           |  |
|   |  | MAY 15 2012   |  |   |  |  |  |  |  |   |  |           |  |

M# 800393473

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certificate: To Be Completed by Physician/Medical Examiner

MATTIELLO, Henry 5/13/12 0014  
Baltimore, Maryland 21215-0036  
Permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15391

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |  |  |
|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Clarence McNeill</b>  |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b>  | 3. Time of Death<br>M                                      |
| 4a. Facility Name (if not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  |
| 4c. County of Death<br>NC  |  |  |  |  |
| 5. Social Security Number<br><b>214-58-5491</b><br>Usual Residence of Decedent   |  |  | 6. Sex<br><b>M</b>   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.           |
|  |  |  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.                        |
|  |  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>11 28 51</b>  | 9. Birthplace (State or Foreign Country)<br>NC             |
| 10a. State<br><b>MD</b>  |  |  | 10b. County<br><b>NA</b>   |  |
| 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><b>Yes</b> 2 <b>No</b>  |  |
| 10e. Street and Number<br><b>1705 North Port Street</b>  |  |  | 10f. Zip Code<br><b>21213</b>  | 10g. Citizen of What Country?<br><b>U.S.A.</b>             |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  |
|  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>Black</b>   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>na</b>  |  |
|  |  |  | 16b. Kind of Business/Industry<br><b>Johns Hopkins University</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence McNeill Sr.</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bernice McNeill</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sheila McNeill-Wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1705 North Port Street, Baltimore, Md 21213</b>  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  | Date<br><b>5/16/2012</b>                                   |
| 20c. Location - City or Town, State<br><b>Woodlawn, Md</b>   |  |  |  |  |
| 21. Signature of Funeral Service License<br><b>Donald C. Shugrue</b>   |  |  | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, Md 21215</b>   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  | Approximate Interval Between Onset and Death   |  |
| a. Due to (or as a consequence of):<br><b>Asthma</b>   |  |  |  |  |
| b. Due to (or as a consequence of):  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown    |  |
|  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |
|  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOD<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                                   |
|  |  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred                          |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Stephen C. Vieil</b>   |  |  | 29c. License number<br><b>KES-000</b>  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen C. Vieil</b>  |  |  | 1800 N. Orleans St Baltimore MD 21287  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  |  | 32. Registrar's Signature<br><b>James A. Parker</b>  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15392

**1-For State Registrar****Physician/Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1034 hrs |
| <b>Christopher J. Mobley</b>             | May 8, 2012                        |                              |

|  |                                      |                     |
|--|--------------------------------------|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| Sinai Hospital   | Baltimore                            |                     |

**Funeral Director**

|                           |  |   |   |   |  |
|---------------------------|--|---|---|---|--|
| 5. Social Security Number | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>28 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>06 27 83 | 9. Birthplace (State or Foreign Country)<br>MD |
|---------------------------|--|---|---|---|--|

|                             |  |  |  |  |  |
|-----------------------------|--|--|--|--|--|
| Usual Residence of Decedent |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|-----------------------------|--|--|--|--|--|

|                  |                          |   |  |  |  |
|------------------|--------------------------|---|--|--|--|
| 10a. State<br>MD | 10b. County<br>Baltimore | 10c. City, Town or Location<br>Windsor Mill |  |  |  |
|------------------|--------------------------|---|--|--|--|

|  |                        |   |
|--|------------------------|---|
| 10e. Street and Number<br>5106 Windsor Mill Road | 10f. Zip Code<br>21207 | 10g. Citizen of What Country?<br>U.S.A. |
|--|------------------------|---|

|  |  |   |  |
|--|--|---|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
|--|--|---|--|

|  |  |  |
|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th grade | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>na | 16b. Kind of Business/Industry<br>Unemployed |
|--|--|--|

|  |   |
|--|---|
| 17. Father's Name (First, Middle, Last)<br>William J. Mobley | 18. Mother's Name (First, Middle, Maiden Surname) |
|--|---|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, First)<br>Carrollton Garner-Mother | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5106 Windsor Mill Road, Baltimore, Md 21207 |
|--|--|

|   |  |                   |   |
|---|--|-------------------|---|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Park | Date<br>5/14/2012 | 20c. Location - City or Town, State<br>Woodlawn, Md |
|---|--|-------------------|---|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br>Donald C. Bright | 22. Name and Address of Facility<br>March F/H West |
|---|--|

|                                      |
|--------------------------------------|
| 4300 Wabash Ave, Baltimore, Md 21215 |
|--------------------------------------|

**Baltimore, MD 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 2a or 2s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Physician/Medical Examiner****Medical Examiner**

**Division of Vital Records, P.O. Box 68760**  
**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
|---|--|

|   |  |
|---|--|
| Immediate Cause (Final disease or condition resulting in death) | a. <b>Gunshot Wounds (2) of Left Arm and Head with Complications</b><br>Due to (or as a consequence of): |
|---|--|

|  |                                     |
|--|-------------------------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |
|--|-------------------------------------|

|                                     |                                     |
|-------------------------------------|-------------------------------------|
| c. Due to (or as a consequence of): | d. Due to (or as a consequence of): |
|-------------------------------------|-------------------------------------|

|                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED |
|-----------------------------------|----------------------------------|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|--|

|  |   |                                 |   |   |
|--|---|---------------------------------|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>May 1, 2012 | 28b. Time of Injury<br>2119 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Subject shot |
|--|---|---------------------------------|---|---|

|  |   |
|--|---|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Street | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>3400 block Piedmont Avenue, Baltimore, MD |
|--|---|

|  |                                 |  |
|--|---------------------------------|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 9, 2012 |
|--|---------------------------------|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|---|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012 | 32. Registrar's Signature<br>Suzanne B. Hart |
|--|--|

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15393

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |   |
|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kelvin Marshall</b>   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>1</b> Year <b>2012</b>  | 3. Time of Death<br><b>12:50 PM</b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Southern Maryland Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |   |
| 4c. County of Death<br><b>Prince George's</b>  |  |   |   |   |
| 5. Social Security Number<br><b>217-86-8032</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.  |
| Usual Residence of Decedent<br><b>MD</b>   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 30 1962</b>   |   |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Cheverly, MD</b>   |
| 10c. City, Town or Location<br><b>Landover</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>7905 Greenleaf Road</b>   |  |   | 10f. Zip Code<br><b>20785</b>   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10th</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Utility Worker</b>   |   | 16b. Kind of Business/Industry<br><b>Private</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Marshall</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Cleveland</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn Marshall / Sister</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7905 Greenleaf Road, Landover, Maryland 20785</b> |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Riverdale Crematory</b>  |   | Date<br><b>05/23/2012</b>   |
| 20c. Location - City or Town, State<br><b>Riverdale, Maryland</b>  |  |   |   |   |
| 21. Signature of Funeral Service Licensee<br><b>Daphney N. Cornelius</b>   |  | 22. Name and Address of Facility J.B. Jenkins Funeral Home<br><b>7474 Landover Road, Landover, Maryland 20785</b>   |   |   |
| 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   |   |   |
| <p>a. <i>Multidrug Resistant Pseudomonas Pneumonia</i><br/>Due to (or as a consequence of):</p> <p>b. <i>Bacillus cereus</i> <i>Bacillemia</i><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |  |   |   |   |
| Approximate Interval Between Onset and Death   |  |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Respiratory Failure</i><br><i>Anoxic Brain injury</i>   |  |   |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |   |
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29b. Signature and title of certifier<br><b>Dr. ADITYA KADIYALA MD</b>   |  | 29c. License number<br><b>D72931</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 2nd 2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. ADITYA KADIYALA 7503 Surrats Road Clinton MD 20735</b>  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><i>Leanne J. Farak</i>   |   |   |

State  
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15394

For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Rose Manzari

2. Date of Death

Month

Day

Year

3. Time of Death

MAY

11

2012

2:01 A<sup>M</sup>

4a. Facility Name (if not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220-36-0193

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

06/23/1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

MD

Harford

10a. State

10b. County

Edgewood

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

1903 Steven Drive

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Angelo Manzari

18. Mother's Name (First, Middle, Maiden Surname)

Mary Re

19a. Informant's Name/Relationship (Type, Print)

George Mergler / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Grier Nursery Farm Ct., Street, MD 21154

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Anatomy Gifts Registry

Date

20c. Location - City or Town, State

05/15/2012

Hanover, Maryland

21. Signature of Funeral Service Licensee

► BO

22. Name and Address of Facility

Anatomy Gifts Registry

7522 Connelley Dr., Ste. P, Hanover, MD 21076

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

EIGHT DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

SEPSIS

a. Due to (or as a consequence of):

METASTATIC SMALL CELL LUNG CANCER

MONTHS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?  
1  Yes 2  No

26. Place of Death (Check only one)

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► RL Chan MD

29c. License number

053430

29d. Date signed (Month, Day, Year)

MAY 11 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRED CHAN MD 6701 NORTH CHARLES STREET SUIT 3808 BALTIMORE MARYLAND 21201

31. Date filed (Month, Day, Year)

NAY 15 2012

32. Registrar's Signature

James D. Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 25,27,28a-f per me, g927, 05/11/2012dhp

Certificate of Death

Reg. No.

2012 15395

1 - For  
State  
Registrar

Amend Items 25,27,28a-f per me, g927, 05/11/2012dhp

Certificate of Death

Reg. No.

2012 15395

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

#23A ME  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |   |   |   |  |   |  |  |
|--|--|---|---|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death<br>Hour:Minute AM/PM   |  |   |  |  |
| <b>Mary Moylan</b>   |  | <b>April 20 2012</b>  |   | <b>10:24 PM</b>   |  |   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Harbor Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   |  |   |  |  |
| 4c. County of Death  |  |   |   |   |  |   |  |  |
| 5. Social Security Number<br><b>002-14-4822</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>88 Yrs.   |  |   |  |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb 24, 1924</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maine</b>  |   | 10. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Catonsville</b>   |  |   |  |  |
| 10e. Street and Number<br><b>715 Maiden Choice Lane RGT 414</b>  |  |   | 10f. Zip Code<br><b>21228</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>4 <b>Bookkeeper</b>   |   | 16b. Kind of Business Industry<br><b>Construction</b>   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ransome J. Garrett</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Furlong</b>  |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jan Wagner- Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>327 Warren Avenue, Unit D, Baltimore, MD 21230</b>          |   |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Mary Moylan</b>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |   | Date<br><b>Apr 23, 2012</b>  | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>           |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Mary Moylan</b>  |  |   | 22. Name and Address of Facility<br><b>Sterling Ashton Schwab Witzke Funeral Home of Catonsville, INC.</b><br><b>1630 Edmondson Ave., Catonsville, MD 21228</b> |   |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   | Approximate Interval Between Onset and Death  |   |  |   |  |  |
| a. <b>Subdural Hematoma</b><br>Due to (or as a consequence of):  |  |   |   |   |  |   |  |  |
| b. Due to (or as a consequence of):  |  |   |   |   |  |   |  |  |
| c. Due to (or as a consequence of):  |  |   |   |   |  |   |  |  |
| d. Due to (or as a consequence of):  |  |   |   |   |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |   | 23f. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)<br><b>04/16/2012</b>  |   | 28b. Time of injury<br><b>Unknown</b>   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>Subject fell.</b>               |  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found: Assisted Living Facility</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Found: 115 Maiden Choice Lane, RGT414, Catonsville, MD 21228</b>   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Kunal Kothari M.D.</b>   |  |   | 29c. License number<br><b>RES 001</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 20, 2012</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kunal Kothari 3001 SOUTH HANOVER STREET, BALTIMORE MD 21225</b>   |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Suzanne S. Parker</b>   |   |   |  |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15396

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

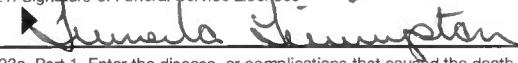
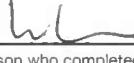
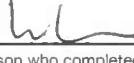
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |             |  |                                |  |                                     |   |  |   |    |
|--|-------------|--|--------------------------------|--|-------------------------------------|---|--|---|----|
| 1. Decedent's Name (First, Middle, Last)   |             | 2. Date of Death   |                                |  |                                     | 3. Time of Death  |  |   |    |
| John Maddox  |             | Month  | Day                            | Year   | 2:15 A M                            |   |  |   |    |
| 4a. Facility Name (if not institution, give street and number)   |             | 4b. City, Town, or Location of Death   |                                |  |                                     | 4c. County of Death   |  |   |    |
| Sinai Hospital   |             | Baltimore  |                                |  |                                     | NA  |  |   |    |
| 5. Social Security Number  |             | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.                    | 8. Date of Birth  | 9. Birthplace (State or Foreign Country)       |   |    |
| 219-28-1023  |             | <input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 79 Yrs.                        | Months   | Days                                | Hours   | Min.   | 04-27-33                                | MD |
| Usual Residence of Decedent  |             |  |                                |  |                                     |   |  |   |    |
| 10a. State   | 10b. County | 10c. City, Town or Location  |                                |  |                                     | 10d. Inside City Limits   |  |   |    |
| MD   | NA          | Baltimore  |                                |  |                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |
| 10e. Street and Number   |             |  |                                | 10f. Zip Code  |                                     |   | 10g. Citizen of What Country?                  |   |    |
| 2525 W. Belvedere Avenue   |             |  |                                | 21215  |                                     |   | USA  |   |    |
| 11. Marital Status   |             | 12. Was Decedent Ever in U.S. Armed Forces?  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     |   | 14. Race - American Indian, Black, White, etc. |   |    |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |             | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |                                     |   | African American                               |   |    |
| 15. Decedent's Education (Specify only highest grade completed)  |             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |                                | 16b. Kind of Business Industry   |                                     |   |  |   |    |
| Elementary/Secondary (0-12)<br>12th Grade  |             | College (1-4 or 5+)<br>NA  |                                | Lab Assistant  |                                     |   | University of MD. Dental School                |   |    |
| 17. Father's Name (First, Middle, Last)  |             |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)  |                                     |   |  |   |    |
| John Maddox  |             |  |                                | Martha Patterson   |                                     |   |  |   |    |
| 19a. Informant's Name/Relationship (Type, Print)   |             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                                |  |                                     |   |  |   |    |
| Terry Sullivan-Guardian  |             | 10 N. Calvert Street Suite #200 Baltimore, MD 21202  |                                |  |                                     |   |  |   |    |
| 20a. Method of Disposition   |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                | Date   | 20c. Location - City or Town, State |   |  |   |    |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |             | Mt. Zion Cem.  |                                | 05-17-12   | Lansdowne, MD                       |   |  |   |    |
| 21. Signature of Funeral Service Licensee  |             | 22. Name and Address of Facility   |                                |  |                                     |   |  |   |    |
|   |             | Wylie Funeral Home P.A.<br>638 N. Gilmor Street Baltimore, Maryland 21217  |                                |  |                                     |   |  |   |    |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |             |  |                                |  |                                     |   |  |   |    |
| Immediate Cause (Final disease or condition resulting in death)  |             |  |                                |  |                                     |   |  |   |    |
| a. <u>Cardiovasclar Disease</u><br>Due to (or as a consequence of):  |             |  |                                |  |                                     |   |  |   |    |
| b. <u>Hypertension</u><br>Due to (or as a consequence of):   |             |  |                                |  |                                     |   |  |   |    |
| c. <u>Diabetes Type II</u><br>Due to (or as a consequence of):   |             |  |                                |  |                                     |   |  |   |    |
| d. _____   |             |  |                                |  |                                     |   |  |   |    |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |             | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |                                |  |                                     |   |  | 23d. Date of delivery<br>Month Day Year |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |  |                                |  |                                     |   |  |   |    |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |             |  |                                |  |                                     |   |  |   |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |                                     |   |  |   |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |             | 28a. Date of injury (Month, Day, Year)   |                                | 28b. Time of injury  | 28c. Injury at work?<br>M           | 28d. Describe how injury occurred                                   |  |   |    |
|  |             |  |                                |  |                                     |   |  |   |    |
|  |             |  |                                |  |                                     |   |  |   |    |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |                                     |   |  |   |    |
|  |             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |                                     |   |  |   |    |
| 29b. Signature and title of certifier<br>   |             | 29c. License number  |                                |  |                                     | 29d. Date signed (Month, Day, Year)                                 |  |   |    |
|   |             | H0064267   |                                |  |                                     | 5-12-12   |  |   |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |             |  |                                |  |                                     |   |  |   |    |
| Dr Karen S. Brown  |             | 1827 Linden Av Balt, MD. 21201   |                                |  |                                     |   |  |   |    |
| 31. Date filed (Month, Day, Year)  |             | 32. Registrar's Signature  |                                |  |                                     |   |  |   |    |
| MAY 15 2012  |             |   |                                |  |                                     |   |  |   |    |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15397

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

3

State  
Registrar

|                                   |  |  |  |   |  |  |  |  |   |  |                              |  |
|-----------------------------------|--|--|--|---|--|--|--|--|---|--|------------------------------|--|
| Physician/<br>Medical<br>Examiner |  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Lewis Marsh, Jr.</b>   |  |   |  |  |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> , Year <b>2012</b>   |  | 3. Time of Death<br>7:45 P M |  |
| Funeral<br>Director               |  | 4a. Facility Name (If not institution, give street and number)<br><b>Kline Hospice House</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Mt. Airy</b>  |  |  |  | 4c. County of Death<br><b>Frederick</b>   |  |                              |  |
|                                   |  | 5. Social Security Number<br><b>212-62-3179</b>  |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>58</b><br>Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb 23, 1954</b>    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |                              |  |
|                                   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Thurmont</b>   |  |  |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |                              |  |
|                                   |  | 10e. Street and Number<br><b>17 E. Moser Road</b>  |  |   |  | 10f. Zip Code<br><b>21788</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |                              |  |
|                                   |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |                              |  |
|                                   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>             |  |  |  | 16b. Kind of Business/Industry<br><b>Factory</b>  |  |                              |  |
|                                   |  | 17. Father's Name (First, Middle, Last)<br><b>Robert Lewis Marsh, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Janet Marie Kendall</b>  |  |  |   |  |                              |  |
|                                   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet M. Marsh / Mother</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 E. Moser Rd. Thurmont, MD 21788</b> |  |  |  |   |  |                              |  |
|                                   |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Final Journey Crematory</b>  |  |  | Date<br><b>5/15/2012</b>   | 20c. Location - City or Town, State<br><b>Woodbine, Maryland</b> |   |  |                              |  |
|                                   |  | 21. Signature of Funeral Service Licensee<br><b>Beverly L. Heckrotte</b>   |  | 22. Name and Address of Facility<br><b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>   |  |  |  |  |   |  |                              |  |
|                                   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)               |  |   |  | Approximate Interval Between Onset and Death<br><b>months</b>  |  |  |   |  |                              |  |
|                                   |  | <p>a. Due to (or as a consequence of):<br/><b>Lung Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |  |  |  |  |   |  |                              |  |
|                                   |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>              |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |                              |  |
|                                   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |                              |  |
|                                   |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)</b> |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |                              |  |
|                                   |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                      | 28d. Describe how injury occurred                                |   |  |                              |  |
|                                   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |                              |  |
|                                   |  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner 3 <input type="checkbox"/> Certifying Nurse Practitioner</b>   |  | 29b. Signature and title of certifier<br><b>Eric Bush MD</b>  |  |  | 29c. License number<br><b>D68104</b>   | 29d. Date signed (Month, Day, Year)<br><b>5/11/12</b>            |   |  |                              |  |
|                                   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eric Bush MD, 516 Trail Ave, Frederick, MD 21702</b>   |  |  |  |  |   |  |                              |  |
|                                   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Leanne J. Parker</b>  |  |  |  |  |   |  |                              |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15398

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| Johnnie Obra Miller                      | May 11, 2012                       | 8:15 p M         |

|  |                                      |                     |
|--|--------------------------------------|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| 1305 Old Joppa Road  | Joppa                                | Harford             |

|                           |  |  |   |  |  |
|---------------------------|--|--|---|--|--|
| 5. Social Security Number | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>May 15, 1931 | 9. Birthplace (State or Foreign Country)<br>North Carolina |
| 215-32-2478               |  | 80                                     |   |  |  |

|            |             |                             |  |
|------------|-------------|-----------------------------|--|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| Maryland   | Harford     | Joppa                       |  |

|                        |               |                               |
|------------------------|---------------|-------------------------------|
| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| 1305 Old Joppa Road    | 21085         | USA                           |

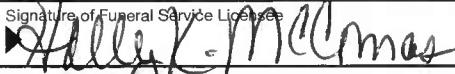
|  |   |   |  |
|--|---|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|--|---|---|--|

|  |  |   |
|--|--|---|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Finisher | 16b. Kind of Business Industry<br>Rubber Manufacturer |
|--|--|---|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>Wiley Fields Craven | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Jane Lyons |
|--|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Stangeland / Daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1103 Grandeur Dr., Salisbury, North Carolina 28146 |
|--|---|

|   |   |                 |   |
|---|---|-----------------|---|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Highview Mem. Gdns. | Date<br>5-15-12 | 20c. Location - City or Town, State<br>Fallston, Maryland |
|---|---|-----------------|---|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br>McComas Funeral Home, P.A.<br>1317 Cokesbury Rd., Abingdon, MD 21009 |
|--|--|

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|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | 23b. Due to (or as a consequence of):<br><br><b>Congestive Heart Failure</b> | Approximate Interval Between Onset and Death<br>1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a consequence of):<br><br><b>Mitral valve disease</b>       | 10 years   |
|  | c. Due to (or as a consequence of):<br><br><b>Aortic valve disease</b>       | 10 years   |
|  | d. Due to (or as a consequence of):<br><br><b>Rheumatic fever</b>            | 73 years   |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|   |  |  |
|---|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><i>Anemia</i> |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|---|--|--|

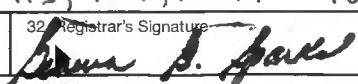
|   |  |  |
|---|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|---|--|--|

|  |   |                          |  |                                   |
|--|---|--------------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury<br>(Month, Day, Year) | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|---|--------------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |                               |   |
|--|-------------------------------|---|
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br>D15827 | 29d. Date signed (Month, Day, Year)<br>May 12, 2012 |
|--|-------------------------------|---|

|   |   |
|---|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Glynn M. Wells, MD, MPH | Patient First Bel Air, MD 560 west macPhail |
|---|---|

|  |  |
|--|--|
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012 | 32. Registrar's Signature<br> |
|--|--|

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15399

**1- For State Registrar**

|                                   |  |  |                              |
|-----------------------------------|--|--|------------------------------|
| <b>Physician/Medical Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>Patrick Donald Machen</b> | 2. Date of Death<br>Month Day Year<br><b>May 7, 2012</b> | 3. Time of Death<br>0932 hrs |
|-----------------------------------|--|--|------------------------------|

4a. Facility Name (if not institution, give street and number)  
**Montgomery General Hospital**4b. City, Town, or Location of Death  
**Olney**4c. County of Death  
**Montgomery**

|   |                            |  |   |  |   |
|---|----------------------------|--|---|--|---|
| 5. Social Security Number<br><b>281-60-8248</b> | 6. Sex<br><b>1 X M 2 F</b> | 7. Age (In yrs. last birthday)<br><b>50 Yrs.</b> | If Under 1 Year<br>Months Days Hours Min.<br><b> </b> | 8. Date of Birth (MM/DD/YYYY)<br><b>April 14, 1962</b> | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|---|----------------------------|--|---|--|---|

## Usual Residence of Decedent

|                         |                                  |   |   |
|-------------------------|----------------------------------|---|---|
| 10a. State<br><b>MD</b> | 10b. County<br><b>Montgomery</b> | 10c. City, Town or Location<br><b>Rockville</b> | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 X No</b> |
|-------------------------|----------------------------------|---|---|

|  |                               |   |
|--|-------------------------------|---|
| 10e. Street and Number<br><b>5312 Crestedge Lane</b> | 10f. Zip Code<br><b>20853</b> | 10g. Citizen of What Country?<br><b>United States</b> |
|--|-------------------------------|---|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <b>White</b> | 14. Race - American Indian, Black, White, etc. |
|--|---|--|--|

|  |  |   |
|--|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self Employed Contractor / Handyman | 16b. Kind of Business/Industry<br><b>Various Jobs</b> |
|--|--|---|

1

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>James Turner Machen</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Margaret Duffield</b> |
|---|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Samantha Machen / Daughter</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19323 Keymar Way, Gaithersburg, MD 20886</b> |
|---|--|

|  |   |                           |  |
|--|---|---------------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>mc0382</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b> | Date<br><b>05/14/2012</b> | 20c. Location - City or Town, State<br><b>Beltsville, MD</b> |
|--|---|---------------------------|--|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br><b>Stefan Johnson</b> | 22. Name and Address of Facility<br><b>Rapp Funeral and Cremation Services<br/>933 Gist Ave., Silver Spring, MD 20910</b> |
|--|---|

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Opioid(Oxycodone, Fentanyl) Intoxication and cocaine</b> | Approximate Interval Between Onset and Death |
| a. <b>And Alprazolam Use</b><br>Due to (or as a consequence of):<br>b.<br>c.<br>d.  |  |
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a,pt.II,27,28a-f,per me,g927 5-30-12 sm   |  |

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |   |
|--|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cirrhosis of the liver, Hepatitis C, Aortic Valve</b> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |
| <b>Insufficiency and coronary Artery Disease</b>   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |

|   |   |                                     |
|---|---|-------------------------------------|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other | 26. Place of Death (Check only one) |
|---|---|-------------------------------------|

|  |  |  |   |   |
|--|--|--|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br><b>fd 5-7-12</b>   | 28b. Time of Injury<br><b>fd 8:40 am</b> | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br><b>unknown</b> | 28d. Describe how injury occurred   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br><b>Found at Residence</b> |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5312 Crestedge Ln.<br/>Rockville, MD</b> |

|   |  |   |
|---|--|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b> |
|---|--|---|

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| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Victor Weeden MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><b>James J. Farley</b> |
|---|---|

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, a Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15400

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |   |   |  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Salvatore L. Massimillo Jr.</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>9</b> Year <b>2012</b>  | 3. Time of Death<br><b>3:50 P M</b>   |  |                                   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   |  |                                   |
| 4c. County of Death<br><b>Montgomery</b>   |  |   |   |  |                                   |
| 5. Social Security Number<br><b>109-34-4061</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>69 Yrs.</b>  |  |                                   |
| 8. Usual Residence of Decedent<br><b>MD Montgomery</b>   |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.   |  |                                   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>  |   |  |                                   |
| 10c. City, Town or Location<br><b>Silver Spring</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                                   |
| 10e. Street and Number<br><b>15310 Pine Orchard Dr. #1F</b>  |  | 10f. Zip Code<br><b>20906</b>   | 10g. Citizen of What Country?<br><b>United States</b>   |  |                                   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |  |                                   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Operator</b>  | 16b. Kind of Business/Industry<br><b>Food Distribution</b>  |  |                                   |
| 17. Father's Name (First, Middle, Last)<br><b>Salvatore L. Massimillo Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Hogan</b>  |   |  |                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Angelina Massimillo / Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15310 Pine Orchard Dr. #1F, Silver Spring, MD 20906</b>   |   |  |                                   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Chesapeake Crematory</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   | Date<br><b>05/16/2012</b>   |  |                                   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Rapp Funeral and Cremation Services<br/>933 Gist Ave., Silver Spring, MD 20910</b>   |   |  |                                   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death  |   |  |                                   |
| <p>a. Due to (or as a consequence of):<br/><b>CLOSTRIDIUM DEFFICITE COLITIS</b></p> <p>b. Due to (or as a consequence of):<br/><b>COLON CANCER</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>  |  |   |   |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  |                                   |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |                                   |
|  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |                                   |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |                                   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D45471</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 9, 2012</b>                        |                                   |
| 29b. Signature and title of certifier<br>   |  |   |   |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NEHEYIS NEGUSSIE M.D., 1500 FOREST GLEN RD., SILVER SPRING, MD 20910</b>  |  |   |   |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |                                   |

Baltimore, Maryland 21215-0036

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Medical Certificate: To Be Completed by Physician/Medical Examiner

3/

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15401

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)

Doris Hazel Marvel

2. Date of Death

Month

5

Day

7

Year

2012

3. Time of Death

8:36P M

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

214-14-4722

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

11/11/1921

3. Time of Death

8:36P M

Usual Residence of Decedent

MD

Anne Arundel

10a. State

10b. County

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

200

Norman Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herbert Turner

18. Mother's Name (First, Middle, Maiden Surname)

Irma Warfield

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert Lee Marvel / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

514 Arbor Drive Glen Burnie, MD 21061

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee MO1479

Selena Polasky

22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD

Singleton Funeral &amp; Cremation Services, PA

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of): Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural2  Pending Investigation3  Accident4  Suicide5  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Downing

MD

29c. License number

DS0108

29d. Date signed (Month, Day, Year)

5/8/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Downing 7845 Oakwood Road, Suite 200 Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

Leanne D. Parker

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15402

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |  |  |  |   |   |  |  |  |                 |  |     |      |
|--|--|--|--|--|---|---|--|--|--|-----------------|--|-----|------|
|  |  | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death   |   | 3. Time of Death  |  |  |  |                 |  |     |      |
|  |  | <b>PAUL G. MUELLER</b>   |  | Month <b>5</b> Day <b>9</b> Year <b>2012</b>   |   | Time <b>3:03 P.M.</b>   |  |  |  |                 |  |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |   | 4c. County of Death   |  |  |  |                 |  |     |      |
|  |  | <b>Mandarin Hospice House</b>  |  | <b>Harwood</b>   |   | <b>Anne Arundel</b>   |  |  |  |                 |  |     |      |
| Funeral<br>Director  |  | 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. last birthday)   | If Under 1 Year   | If Under 24 Hrs.  | 8. Date of Birth (Month, Day, Year)  | 9. Birthplace (State or Foreign Country) |  |                 |  |     |      |
|  |  | <b>219-18-2674</b>   | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 86 Yrs.  | Months  | Days  | Hours  | Min.                                     | <b>06/09/1925</b>  | <b>Illinois</b> |  |     |      |
| Usual Residence of Decedent  |  | 10a. State   | 10b. County  | 10c. City, Town or Location  |   |   |  |  | 10d. Inside City Limits  |                 |  |     |      |
|  |  | <b>MD</b>  | <b>Anne Arundel</b>  | <b>Pasadena</b>  |   |   |  |  | <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                 |  |     |      |
| To Be Completed by Funeral Director                                |  | 10e. Street and Number   |  |  | 10f. Zip Code   |   |  | 10g. Citizen of What Country?            |  |                 |  |     |      |
|  |  | <b>8001 Middlebury Drive</b>   |  |  | <b>21122</b>  |   |  | <b>U.S.A.</b>                            |  |                 |  |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |  | 14. Race - American Indian, Black, White, etc.                                 |                 |  |     |      |
|  |  | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.                 |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                            |  |  | Specify: <b>White</b>  |                 |  |     |      |
| To Be Completed by Physician/Medical Examiner                      |  | 15. Decedent's Education (Specify only highest grade completed)  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |   |  | 16b. Kind of Business/Industry           |  |                 |  |     |      |
|  |  | Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b><br><b>8+</b>  |  |  | <b>Doctor</b>   |   |  | <b>Healthcare</b>                        |  |                 |  |     |      |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)   |   |  |  |  |                 |  |     |      |
|  |  | <b>Paul Godfrey Mueller</b>  |  |  | <b>Oral Wiley</b>   |   |  |  |  |                 |  |     |      |
| To Be Completed by Funeral Director                                |  | 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)                          |   |   |  |  |  |                 |  |     |      |
|  |  | <b>Daughter</b><br><b>Mrs. Beth A. Guizzardi /</b>   |  | <b>9200 Stone Spring Lane Pasadena, MD 21122</b>   |   |   |  |  |  |                 |  |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |   |   | Date   | 20c. Location - City or Town, State      |  |                 |  |     |      |
|  |  | 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | <b>Balto. National Cem.</b>  |   |   | <b>05/15/2012</b>  | <b>Baltimore, MD</b>                     |  |                 |  |     |      |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility   |   |   | 1 2nd Avenue SW Glen Burnie, MD  |  |  |                 |  |     |      |
|  |  | <b>Selena Polinsky</b>   |  | <b>Singleton Funeral &amp; Cremation Services, PA</b>  |   |   |  |  |  |                 |  |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |  |  |                 | Approximate Interval Between Onset and Death   |     |      |
|  |  | <b>Sepsis</b>  |  |  |   |   |  |  |  |                 |  |     |      |
| To Be Completed by Physician/Medical Examiner                      |  | 23b. Was decedent pregnant in the past 12 months?  |  |  |   |   |  |  |  |                 | IF FEMALE:   |     |      |
|  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |   |   |  |  |  |                 | 23c. If yes, outcome of pregnancy  |     |      |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |  |   |   |  |  |  |                 | 23d. Date of delivery  |     |      |
|  |  |  |  |  |   |   |  |  |  |                 | Month  | Day | Year |
| To Be Completed by Funeral Director                                |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |  |  |                 | 23e. Did tobacco use contribute to the cause of death?   |     |      |
|  |  | <b>Diabetes</b>  |  |  |   |   |  |  |  |                 | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 25. Was case referred to medical examiner?   |  | 26. Place of Death (Check only one)  |   |   | 23f. Were autopsy findings available prior to completion of cause of death?  |  |  |                 |  |     |      |
|  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA |   |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No      |  |  |                 |  |     |      |
| To Be Completed by Physician/Medical Examiner                      |  | 27. Manner of Death  |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury   | 28c. Injury at work?   | 28d. Describe how injury occurred        |  |                 |  |     |      |
|  |  | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  |  |   | M   | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                 |  |  |                 |  |     |      |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 29a. Certifier   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                 |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |                 |  |     |      |
|  |  | 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |                 |  |     |      |
| To Be Completed by Funeral Director                                |  | 29b. Signature and title of certifier  |  | 29c. License number  |   |   | 29d. Date signed (Month, Day, Year)  |  |  |                 |  |     |      |
|  |  | <b>Eva Hersh MD</b>  |  | <b>MD 0036581</b>  |   |   | <b>5/10/12</b>   |  |  |                 |  |     |      |
| Physician/<br>Medical<br>Examiner                                  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |  |   |   | <b>445 Defense Hwy<br/>Annapolis, MD 21401</b>                               |  |  |                 |  |     |      |
|  |  | <b>Eva Hersh MD</b>  |  |  |   |   |  |  |  |                 |  |     |      |
| To Be Completed by Funeral Director                                |  | 31. Date filed (Month, Day, Year)  |  | 32. Registrar's Signature  |   |   |  |  |  |                 |  |     |      |
|  |  | <b>MAY 15 2012</b>   |  | <b>Leanne J. Parker</b>  |   |   |  |  |  |                 |  |     |      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15403

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

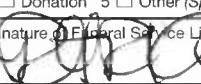
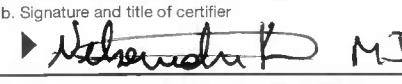
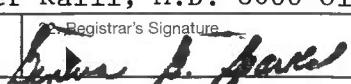
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10V

State  
Registrar

|  |  |   |   |  |  |  |   |
|--|--|---|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>George Patrick McMahon</b>  |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>12</b> , Year <b>2012</b>  | 3. Time of Death<br>7:30 A M   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Suburban Hospital</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  |  |   |
| 5. Social Security Number<br><b>195-30-3420</b>  |  | 6. Sex<br><b>1 X M 2 <input type="checkbox"/> F</b>   | 7. Age (in yrs. last birthday)<br><b>74</b><br>Yrs. | If Under 1 Year<br>Months      Days      Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>August 17, 1937</b>                     |  |   |
| 9. Usual Residence of Decedent<br><b>Maryland</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Germantown</b>   |  |  |   |
| 10e. Street and Number<br><b>1222 Britannia Circle</b>   |  |   |   | 10f. Zip Code<br><b>20874</b>  | 10g. Citizen of What Country?<br><b>United States</b>                                |  |   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 X Married</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 X No</b><br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 X No</b> Specify:<br><b>White</b> |  |  |   |
| 14. Race - American Indian, Black, White, etc.   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |   |  |  |  |   |
| 16a. Decedent's Usual Occupation<br>Director of X-Ray Department   |  | 16b. Kind of Business/Industry<br><b>National Institutes of Health</b>  |   |  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Paul McMahon</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Gutwald</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rose Marie McMahon / Wife</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1222 Britannia Circle, Germantown, Maryland 20874</b>                                |  |  |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 X Cremation 3 <input type="checkbox"/> Removal from State</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forsyth Cremation Service</b>  |   | Date<br><b>May 15, 2012</b>  | 20c. Location - City or Town, State<br><b>Altoona, Pennsylvania</b>                  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814</b>  |   |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |   | Approximate Interval Between Onset and Death<br><b>1 year</b>  |  |  |   |
| a. <b>Hepatorenal Syndrome</b><br>Due to (or as a consequence of):   |  |   |   |  |  |  |   |
| b. Due to (or as a consequence of):  |  |   |   |  |  |  |   |
| c. Due to (or as a consequence of):  |  |   |   |  |  |  |   |
| d. Due to (or as a consequence of):  |  |   |   |  |  |  |   |
| IF FEMALE:   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |  |  |  |   |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month      Day      Year   |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 X No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 X No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 X Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 X No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 27. Manner of Death<br>1 X Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |
| 29a. Certifier<br>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>only one<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br><b>Nelson Gustavo Neder Kalil, M.D.</b>   |   |  |  | 29c. License number<br><b>D51616</b>   | 29d. Date signed (Month, Day, Year)<br><b>May 12, 2012</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nelson Gustavo Neder Kalil, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814</b>   |  |   |   |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   |
| 32. Registrar's Signature<br>   |  |   |   |  |  | 33. Original   |   |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15404

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                               |                  |
|--|-------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death              | 3. Time of Death |
| LEONARD M. MARTIN SR.                    | Month Day Year<br>May 8, 2012 | 0342 hrs         |

**Funeral Director**

|  |                                      |                     |
|--|--------------------------------------|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| Johns Hopkins Hospital   | Baltimore                            | N/A                 |

**To Be Completed by Funeral Director**

**Baltimore, MD 21215-0036**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |                                |                 |                  |                               |  |
|--|--|--------------------------------|-----------------|------------------|-------------------------------|--|
| 5. Social Security Number                          | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign)   |
| 217-84-5436  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 48 Yrs.                        | Months          | Days             | Hours Min.                    | MARYLAND   |
| 10a. State 10b. County 10c. City, Town or Location |  |                                |                 |                  |                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| MARYLAND   | N/A  | BALTIMORE                      |                 |                  |                               |  |
| 10e. Street and Number                             |  |                                | 10f. Zip Code   |                  |                               | 10g. Citizen of What Country?  |
| 2009 BARCLAY ST.                                   |  |                                | 21218           |                  |                               | U.S.A.   |

|  |  |   |  |
|--|--|---|--|
| 11. Marital Status   | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:                            | Specify: BLACK                                 |

|   |   |                                |
|---|---|--------------------------------|
| 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| Elementary/Secondary (0-12) 9th grade                           | College (1-4 or 5+) CHEF/COOK   | FOOD SERVICE                   |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| CARL MARTIN                             | DOROTHY PARRISH                                   |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Leonard M. Martin Jr./Son                        | 2009 Barclay St., Baltimore, Md., 21218   |

|   |  |          |                                     |
|---|--|----------|-------------------------------------|
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date     | 20c. Location - City or Town, State |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify | KING MEMORIAL PARK   | 05-17-12 | BALTIMORE, MARYLAND                 |

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility                                   |
| <i>William C Brown</i>                    | WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.<br>1206 W NORTH AVENUE |

**Physician /Medical Examiner**

|  |  |
|--|--|
| 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)  | a. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of): |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b.<br>Due to (or as a consequence of):   |
| c.<br>Due to (or as a consequence of):   |  |
| d.<br>UNPENDED   | <input checked="" type="checkbox"/> AMENDED 1,23a,27 per me g929 7-25-12 vt          |

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?                                 | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown |   |   |

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|

|  |  |                     |  |  |
|--|--|---------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |  |                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
|  |  |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |

|   |
|---|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

|   |                                 |  |
|---|---------------------------------|--|
| 29b. Signature and title of certifier<br><i>Donna M. Vincenti, MD</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 9, 2012 |
|---|---------------------------------|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|---|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><i>Leonard Martin</i> |
|---|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15405

1- For  
State  
Registrar

**Physician  
/Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)

Shirley Makell

2. Date of Death

Month

Day

Year

3. Time of Death

11:45 P M

**Funeral  
Director**

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-56-4853

6. Sex

M

F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

09/28/1949

9. Birthplace (State or Foreign Country)

Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

2720 E. Biddle St.

10f. Zip-Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

Charles Ragin

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Mosley

19a. Informant's Name/Relationship (Type, Print)

Ronnell Fortune (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1808 W. Lexington St., Baltimore, MD 21223

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

on-site Crematory

Date

5-7-12

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Jacqueline Roane

Name and Address of Facility

Joseph H. Brown Jr. Funeral Home PA

2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Sepsis

Due to (or as a consequence of):

b. Clostridium difficile colitis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No

Unknown

23c. If yes, outcome of pregnancy

Live birth  Fetal death  Ectopic pregnancy

Pregnant at time of death

Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Nonalcoholic Steatohepatitis pancreatitis

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital:

1  Inpatient  ER/Outpatient  DOA

Other:

4  Nursing Home  Residence  Other (Specify)

27. Manner of Death

1  Natural

2  Accident

3  Suicide

4  Homicide

5  Pending investigation

6  Could not be determined

M

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1  Yes  No

28d. Describe how injury occurred

29a. Certifier (check only one)  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

April 28, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isaac Howley, MD

4940 Eastern Avenue, Baltimore, MD, 21224

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

Isaac S. Howley

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State  
Registrar**

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15406

For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
**Rex Vaughn Naylor**

2. Date of Death  
Month **May** Day **12**, Year **2012**  
3. Time of Death  
**1:15 A M**

4a. Facility Name (if not institution, give street and number)  
**Casey House**

4b. City, Town, or Location of Death  
**Rockville**

4c. County of Death  
**Montgomery**

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 2 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

5. Social Security Number  
**235-20-0900**

6. Sex  
**M**

7. Age (In yrs. last birthday)

Yrs.  
**91**

If Under 1 Year  
Months  Days  Hours  Min.

8. Date of Birth  
(Month, Day, Year)

**Nov 15, 1920**

9. Birthplace (State or Foreign Country)

**West Virginia**

Funeral  
Director

10a. State  
**MD**

10b. County  
**Montgomery**

10c. City, Town or Location  
**Gaithersburg**

10d. Inside City Limits  
**1 Yes 2 No**

10e. Street and Number  
**401 Russell Avenue #713**

10f. Zip Code  
**20877**

10g. Citizen of What Country?  
**United States**

11. Marital Status  
1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates  
**1942-46**

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
**Caucasian**

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

**5+**

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

**Speech Pathologist**

16b. Kind of Business/Industry  
**Health Care**

17. Father's Name (First, Middle, Last)  
**Walter L. Naylor**

18. Mother's Name (First, Middle, Maiden Surname)  
**Elfa Sallaz**

19a. Informant's Name/Relationship (Type, Print)  
**Phyllis R. Naylor / Wife**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**401 Russell Ave #713 Gaithersburg, MD 20877**

20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

**Final Journey Crematory**

Date

20c. Location - City or Town, State

**5/16/2012 Woodbine, Maryland**

21. Signature of Funeral Service Licensee  


22. Name and Address of Facility  
**Going Home Cremation Service P.O. Box 784  
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. **Alzheimer's Dementia**

Due to (or as a consequence of):

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month  Day  Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Prostate Cancer**

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify) **Hospice**

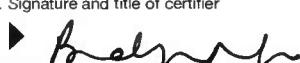
27. Manner of Death  
1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide 7  Homicide  
4  Homicide

28a. Date of injury (Month, Day, Year)  
28b. Time of injury  
M  
28c. Injury at work?  
1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  


29c. License number  
**D60634**

29d. Date signed (Month, Day, Year)  
**May 12, 2012**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**Bindu Joseph 1160 Varnum St. Washington, DC 20017**

31. Date filed (Month, Day, Year)  
**MAY 15 2012**

32. Registrar's Signature  


State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15407

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## To Be Completed by Funeral Director

## Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

|   |  |  |   |   |
|---|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death  |
| <b>MILDRED ETHEL OAKES</b>  |  | 5 9 12   |   | 00:30 AM  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Riverview</b>  |  | 4b. City, Town, or Location of Death<br><b>Essex</b>   |   | 4c. County of Death<br><b>Baltimore</b>   |
| 5. Social Security Number<br><b>213-14-4952</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> XX</b>   | 7. Age (In yrs. last birthday)<br><b>90</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>4/21/22</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>BALTIMORE</b>   |
| 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |   |
| 10e. Street and Number<br><b>620 DUNWICH WAY</b>  |  | 10f. Zip Code<br><b>21221</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>       |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD RAYMOND CARPER</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL UNKNOWN</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CATHY FRANCO - DAUGHTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>613 MARYLAND AVE. BALTIMORE, MD 21221</b>  |   |   |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ATLANTIC CREMATORY</b>  |   | Date<br><b>5/11/12</b>  |
| 21. Signature of Funeral Service Licensee<br><b>J. L. J. m01120</b>   |  | 22. Name and Address of Facility<br><b>SKARDA FUNERAL HOME<br/>2829 HUDSON ST. BALTIMORE, MD 21224</b>   |   | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD</b>   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  |   | Approximate Interval Between Onset and Death  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | a. Due to (or as a consequence of):<br><b>Congestive heart failure</b>   |   |   |
|   |  | b. Due to (or as a consequence of):<br><b>Chronic obstructive pulmonary Disease</b>  |   |   |
|   |  | c. Due to (or as a consequence of):<br><b>Advanced Dementia</b>  |   |   |
|   |  | d. _____   |   |   |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br/>4 <input type="checkbox"/> Pregnant at time of death<br/>9 <input type="checkbox"/> Unknown</b> |   | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  | 26. Place of Death (Check only one)<br>Hospital:<br><b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>  |   | 23f. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |
| 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29c. License number<br><b>110000002</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5-10-12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Natalie Loring 1 Eastern Ave Essex, MD 21221</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   | 32. Registrar's Signature<br><b>J. Parker</b>   |

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Req. No

2012 15408

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| Physician/<br>Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Pasquale Antonio Roberto</b>  |   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 7, 2012</b>   | 3. Time of Death<br>0652 hrs   |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>3223 Lynch Road</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |   |  | 4c. County of Death<br><b>Baltimore County</b>   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>206-68-4634</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>31</b>  | Yrs.  | If Under 1 Year<br>Months<br><input type="checkbox"/>  | If Under 24 Hrs.<br>Days<br><input type="checkbox"/>  | 8. Date of Birth (MM/DD/YYYY)<br><b>08/14/1980</b>         | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |  |  |  |
|   | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Baltimore</b> 10c. City, Town or Location<br><b>Dundalk</b>   |   |  |   |  |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>3223 Lynch Road</b>   |   |  |   | 10f. Zip Code<br><b>21219</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:<br>Specify: <b>White</b> |   |  | 14. Race - American Indian, Black, White, etc.   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Repairman</b>   |  | 16b. Kind of Business/Industry<br><b>Heating and Air Conditioning</b> |  |   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Giovanni Roberto</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Teresa</b>   |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Giovanni Roberto</b> Father  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8901 Bloonfield Place Philadelphia, PA 19115</b> |   |  |   |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:<br><i>Michael P. Margullo</i>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St John Neumann Cem.</b>  |   |  | Date<br><b>05/12/2012</b>   | 20c. Location - City or Town, State<br><b>Chalfont, PA</b> |  |  |  |  |
| 21. Signature of Funeral Service Licensee   |  |   | 22. Name and Address of Facility<br><b>Marzullo Funeral Chapel, P.A.</b><br><b>6009 Harford Road Baltimore, Maryland 21214</b>                       |   |  |   |  |  |  |  |  |
| Physician<br>Medical<br>Examiner  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Oxycodone Intoxication and Cocaine Use</b><br>Due to (or as a consequence of): |   |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |  |  |
|   | b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |   |  |   |  |  |  |  |  |
| c. Due to (or as a consequence of):   |  |   |  |   |  |   |  |  |  |  |  |
| d. Due to (or as a consequence of):   |  |   |  |   |  |   |  |  |  |  |  |
| <input checked="" type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g927 5-16-12 sm  |  |   |  |   |  |  |  |  |  |
| IF FEMALE:  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene     |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>fd 5-7-12</b>  |  | 28b. Time of Injury<br><b>fd 06:40am</b>                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>unknown</b>  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify)<br><b>Found: Residence</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3223 Lynch Rd. Dundalk, MD.</b>  |  |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Ana Rubio</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 7, 2012</b>                                       |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><i>John J. Hayes</i>   |  |   |  |   |  |  |  |  |  |
| State<br>Registrar  |  |   |  |   |  |   |  |  |  |  |  |

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed

**To the Funeral Director:** After this certificate has been signed by the attending physician and within 24 hours after death.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

to Be Committed by Funeral Director

Baltimore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

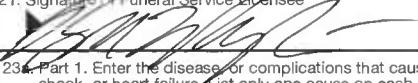
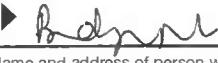
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15409

1- For  
State  
Registrar

|  |   |  |  |   |  |   |  |  |                                   |
|--|---|--|--|---|--|---|--|--|-----------------------------------|
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Clara Joe Rogers</b>   |  |  |   |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>11</b> Year <b>2012</b>                            | 3. Time of Death<br><b>1625</b> M |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |   |  | 4c. County of Death<br><b>Howard</b>   |                                   |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>092-28-3623</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours                                   | 8. Date of Birth<br>(Month, Day, Year)<br><b>7-26-1932</b> | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |                                   |
|  | Usual Residence of Decedent<br><b>MD</b>  |  | 10a. State <b>MD</b> 10b. County <b>Howard</b>   |   | 10c. City, Town or Location<br><b>Columbia</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |
| <b>To Be Completed by Funeral Director</b>   | 10e. Street and Number<br><b>5369 Brook Way, Apt. 6</b>   |  |  |   | 10f. Zip Code<br><b>21044</b>  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |                                   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: <b>African-American</b> |   |  | 14. Race - American Indian, Black, White, etc.   |                                   |
| <b>Physician/<br/>Medical<br/>Examiner</b>   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>                      |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |   |  |  |                                   |
|  | 17. Father's Name (First, Middle, Last)<br><b>General Samuel L. Currie</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Adjie Blanche Gowan</b>  |   |  |  |                                   |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Ann McClung/ Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5369 Brook Way, Apt. 6, Columbia, MD 21044</b> |   |  |   |  |  |                                   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |   | Date<br><b>5-15-2012</b>   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |  |  |                                   |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>Wylie Funeral Home P.A. of Baltimore Co.<br/>9200 Liberty Road, Randallstown, MD 21133</b> |  |   |  |  |                                   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Cancer with unknown Primary</b><br>Approximate Interval Between Onset and Death<br><b>Month</b>   |   |  |  |   |  |   |  |  |                                   |
| <p>a. Due to (or as a consequence of):<br/><b>Metastatic Cancer with unknown Primary</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |   |  |  |   |  |   |  |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                |  |   |  |   | 23d. Date of delivery<br>Month Day Year                    |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |   |  |  |                                   |
| <p>23e. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>  |   |  |  |   |  |   |  |  |                                   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |   |  |   |  |  |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                           |  |  |                                   |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                   |
| 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |  |   |  |  |                                   |
| 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br><b>D0060634</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5/14/12</b>      |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BINDOU JOSEPH 6336 CEDAR LANE, COLUMBIA, MD 21044</b>   |   |  |  |   |  |   |  |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |   | 32. Registrar's Signature<br>   |  |   |  |   |  |  |                                   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15410

Reg. No.

1 - For  
State  
Registrar

|   |  |   |   |   |  |  |   |  |  |  |                                  |  |
|---|--|---|---|---|--|--|---|--|--|--|----------------------------------|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>William Marshall Robertson</b>                |   |   |   |  |  |   | 2. Date of Death<br>Month 05 Day 10 Year 2012                                |  |  | 3. Time of Death<br>3:30p.m.     |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>3312 Parkington Ave</b> |   |   |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                     |  |  | 4c. County of Death<br><b>NC</b> |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-24-7996</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b>   | If Under 1 Year<br>Months<br>Yrs.  | If Under 24 Hrs.<br>Hours<br>Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>09 26 30</b> |  |  | 9. Birthplace (State or Foreign Country)<br><b>U.S.A.</b>                                      |                                  |  |
|   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                  |  |
| 10e. Street and Number<br><b>3312 Parkington Ave</b>  |  |   |   |   | 10f. Zip Code<br><b>21215</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |  |  |                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>      |  |  |                                  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>12th grade</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Purchasing Agent</b> |   |  | 16b. Kind of Business/Industry<br><b>G A F Distribution Co.</b>                  |   |  |  |  |                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Robertson</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Goldston</b>   |  |   |  |  |  |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Douglas Robertson-Son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5305 Old Frederick Road, Baltimore, Md 21229</b>  |  |  |   | Date   | 20c. Location - City or Town, State<br><b>Owings Mills, Md</b> |  |                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |   |  | 20c. Location - City or Town, State<br><b>5/22/2012</b>                          |   |  |  |  |                                  |  |
| 21. Funeral Service Licensee<br><b>Alma C. Wright</b>   |  |   |   | 22. Name and Address of Facility<br><b>March F/H West<br/>4300 Wabash Ave, Baltimore, Md 21215</b>  |  |  |   |  |  |  |                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   |   | 23b. Due to (or as a consequence of):<br><b>END STAGE DEMENTIA</b>  |  |  |   |  | Approximate Interval Between Onset and Death                   |  |                                  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   | 23c. Due to (or as a consequence of):   |  |  |   |  |  |  |                                  |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |   |  |  |   |  |  |  |                                  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown<br>Other (Specify): _____ |  |  |   |  | 23d. Date of delivery<br>Month Day Year                        |  |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |  |  |                                  |  |
|   |  |   |   |   |  |  |   |  |  |  |                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                               |   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): _____                         |  |   |  |  |  |                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |                                  |  |
|   |  |   |   |   |  |  |   |  |  |  |                                  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |                                  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |  |  |                                  |  |
| 29b. Signature and title of certifier<br><b>JACKIE JONES CNP</b>  |  | 29c. License number<br><b>R149792</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/11/2012</b>   |  |  |   |  |  |  |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES CNP 300 JULIANE VALLEY RD TIMONIUM, MD 21093</b>  |  |   |   |   |  |  |   |  |  |  |                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><b>Leanne J. Parker</b>  |   |   |  |  |   |  |  |  |                                  |  |

*May 10, 2012 3:30pm*  
Baltimore, Maryland 21215-0036

WILLIAM ROBERTSON  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For Amend Item 25 per me, g927, 05/11/2012dhb  
State Registrar

Certificate of Death

Reg. No.

2012 1541

|   |  |  |  |  |  |  |  |   |  |   |  |   |  |                              |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|------------------------------|--|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Bryan Scott Rhodes</b>  |  |  |  |  |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>4 - 21 - 12</b>  |  | 3. Time of Death<br>1150 P M |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospital Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  |   |  | 4c. County of Death<br><b>Carroll</b>                       |  |   |  |                              |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>219-06-3595</b>  |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  |  | 7. Age (In yrs. last birthday)<br><b>44 Yrs.</b>   |  | If Under 1 Year<br>Months Days Hours Min.<br><b>44 00 00 00</b>                             |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/01/1967</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |                              |  |
| To Be Completed by Funeral Director           |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>Westminster</b>  |  |   |  |   |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>156 Liberty Street, Apt. A</b>  |  |  |  | 10f. Zip Code<br><b>21157</b>  |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                              |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) Customer Service</b>  |  | 16b. Kind of Business Industry<br><b>Food Service</b>  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Eugene Rhodes</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sonia Louise Bryant</b>  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Muriel Harding / Sister</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>156 Liberty Street, Apt. A, Westminster, MD 21157</b>  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Anatomy Gifts Registry</b>  |  | Date<br><b>05/01/2012</b>  |  | 20c. Location - City or Town, State<br><b>Hanover, Maryland</b>                             |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |  |  | 22. Name and Address of Facility<br><b>Anatomy Gifts Registry<br/>7522 Connelley Dr., Ste.P, Hanover, MD 21076</b>   |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>VENTRICULAR TACHYCARDIA</b>   |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | b. Due to (or as a consequence of):<br><b>ISCHEMIC CARDIOMYOPATHY</b>  |  |  |  |  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | c. Due to (or as a consequence of):  |  |  |  |  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | d. Due to (or as a consequence of):<br><br><b>CERTIFICATE IN PROXY M CALFTIMER</b>   |  |  |  |  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>3 <input type="checkbox"/> Unknown</b>  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br/>9 <input type="checkbox"/> Unknown</b> |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DIABETES MELLITUS TYPE I<br/>ACUTE KIDNEY INJURY</b>  |  |  |  |  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  | 26. Place of Death (Check only one)<br>Hospital:<br><b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>  |  | Other:<br><b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>   |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b>   |  | 28a. Date of injury (Month, Day, Year)<br><b>[Signature]</b>   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  | 28d. Describe how injury occurred                           |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>[Signature]</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>[Signature]</b>   |  |  |  |   |  |   |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |  |  | 29c. License number<br><b>D 30263</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-21-12</b>       |  |   |  |                              |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS KHOO, MD 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157</b>   |  |  |  |  |  |   |  |   |  |   |  |                              |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |   |  |   |  |   |  |                              |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
amend 18, 20c, per fn, g927-5-15-12 sm  
State of Maryland / Department of Health and Mental Hygiene

For  
State  
Registrar

## **Physician/ Medical Examiner**

|   |   |  |                               |  |  |   |  |
|---|---|--|-------------------------------|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anna Smith</b>   |   |  |                               | 2. Date of Death<br>Month <b>5</b> Day <b>7</b> Year <b>2012</b> | 3. Time of Death<br><b>11:40 A M</b>                       |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1400 E. Madison Street Apt. #806</b> |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |                               | 4c. County of Death<br><b>N/A</b>                                |  |   |  |
| 5. Social Security Number<br><b>213-36-5263</b>   | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>77 Yrs.</b>         | If Under 1 Year<br>Months     | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>7-11-1934</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
| Usual Residence of Decedent   |   |  |                               |  |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>   | 10c. City, Town or Location<br><b>Baltimore</b>          |                               |  |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |
| 10e. Street and Number<br><b>1400 E. Madison St.</b>  |   | Apt. # <b>806</b>  | 10f. Zip Code<br><b>21205</b> |  | 10g. Citizen of What Country?<br><b>USA</b>                |   |  |

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|  |  |   |  |
|--|--|---|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  | Approximate Interval Between Onset and Death  |  |
| <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |
| <b>IF FEMALE:</b><br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year  |
| <b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br><b>CONGESTIVE HEART FAILURE</b><br><b>CHRONIC RENAL INSUFFICIENCY</b><br><b>ANEMIA 2° CHRONIC RENAL INSUFFICIENCY</b>   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |  | 28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br>DIS5904 (MD)   |  |
|  |  | 29d. Date signed (Month, Day, Year)<br>15 MAY 2012  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEPHEN J NIGHTINGALE MD Home Physicians PC 705 Digital Dr Gaithersburg MD 20898</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>   |  |

State  
Registrar

Smith Raymond

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15413

1- For  
State  
Registrar

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |   |   |  |   |   |                                     |  |
|--|--|---|--|---|---|---|--|---|---|-------------------------------------|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Raymond Smith</b>  |  |   |   |   |  | 2. Date of Death<br>Month <b>05</b> Day <b>11</b> Year <b>2012</b>  |   | 3. Time of Death<br><b>12:13 PM</b> |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Bon Secours</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   |  | 4c. County of Death<br><b>Baltimore</b>   |   |                                     |  |
|  |  | 5. Social Security Number<br><b>212-24-5856</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month/Day/Year)<br><b>Oct. 9 1927</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |                                     |  |
|  |  | 10a. State <b>Maryland</b>  |  |   | 10b. County   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                                     |  |
|  |  | 10e. Street and Number<br><b>3905 Oxford Avenue</b>   |  |   | 10f. Zip Code<br><b>21215</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |                                     |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |                                     |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal Clerk</b>               |   | 16b. Kind of Business Industry<br><b>U.S. Post Office/Federal Government</b>  |  |   |   |                                     |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Joshua Smith</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Davenport</b>   |   |  |   |   |                                     |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thelma Smith/wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3905 Oxford Ave. Baltimore, Md. 21215</b>   |   |  |   |   |                                     |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>Chetman-Harris</i>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cemetery</b>  |   |  | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>   |   |                                     |  |
|  |  | 21. Signature of Funeral Service Licensee<br><i>Chetman-Harris</i>  |  |   | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home<br/>5240 Reisterstown Rd. Baltimore, Md. 21215</b>   |   |  |   |   |                                     |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |   | <b>Cardio myopathy with possible arrhythmia</b>   |   |  | Approximate Interval Between Onset and Death  |   |                                     |  |
|  |  | a. Due to (or as a consequence of):<br><i>AKT</i>   |  |   |   |   |  |   |   |                                     |  |
|  |  | b. Due to (or as a consequence of):<br><i>CHF</i>   |  |   |   |   |  |   |   |                                     |  |
|  |  | c. Due to (or as a consequence of):<br><i></i>  |  |   |   |   |  |   |   |                                     |  |
|  |  | d. <i></i>  |  |   |   |   |  |   |   |                                     |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year   |   |                                     |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                     |  |
|  |  |   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                     |  |
|  |  |   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                     |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)            |   |  |   |   |                                     |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  |   | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |   |                                     |  |
|  |  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                     |  |
|  |  | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |   |                                     |  |
|  |  | 29b. Signature and title of certifier<br><i>Rebecca J. Jones</i>  |  |   | 29c. License number<br><b>D-72516</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>05/11/2012</b>  |   |                                     |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2000 W. Baltimore St. Baltimore, MD 21223</b>  |  |   |   |   |  |   |   |                                     |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br><i>Rebecca J. Jones</i>  |   |   |  |   |   |                                     |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15414

**1 - For  
State  
Registrar**

**Physician/  
Medical  
Examiner**

|  |  |  |                                |  |  |  |   |
|--|--|--|--------------------------------|--|--|--|---|
|  |  | 1. Decedent's Name (First, Middle, Last)   |                                |  |  | 2. Date of Death   | 3. Time of Death  |
|  |  | John Joseph Scocca   |                                |  |  | Month May 10 Day 2012 Year   | 9:50 A M  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |                                |  |  | 4c. County of Death  |   |
| Gilchrist Center   |  | Towson   |                                |  |  | Baltimore  |   |
| 5. Social Security Number  |  | 6. Sex   | 7. Age (In yrs. last birthday) | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birth   | 9. Birthplace (State or Foreign Country)                                |
| 185-32-2684  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 72 Yrs.                        | Months   | Days   | Hours  | Min.  |
| Usual Residence of Decedent  |  |  |                                |  |  | Mar. 23, 1940 Pennsylvania   |   |
| 10a. State   |  | 10b. County  | 10c. City, Town or Location    |  |  |  | 10d. Inside City Limits   |
| Maryland   |  | Harford  | Aberdeen                       |  |  |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number   |  | 10f. Zip Code  |                                |  |  | 10g. Citizen of What Country?  |   |
| 1316 Aldino-Stepney Road   |  | 21001  |                                |  |  | United States  |   |
| 11. Marital Status   |  | 12. Was Decedent Ever in U.S. Armed Forces?  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  | 14. Race - American Indian, Black, White, etc. Specify: White  |   |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                             |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |                                |  |  | 16b. Kind of Business/Industry Johns Hopkins School of Hygiene   |   |
| Elementary/Secondary (0-12)  |  | College (1-4 or 5+) 5+ Biochemistry Professor  |                                |  |  |  |   |
| 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name (First, Middle, Maiden Surname)  |                                |  |  |  |   |
| Rudolph Victor Hugo Scocca   |  | Clara Zulli  |                                |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |                                |  |  |  |   |
| Jane Scocca / Wife   |  | 1316 Aldino-Stepney Rd., Aberdeen, Maryland 21001  |                                |  |  |  |   |
| 20a. Method of Disposition   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                | Date   | 20c. Location - City or Town, State  |  |   |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Metro Crematory Inc  |                                | 05/11/2012   | Baltimore, Maryland  |  |   |
| 21. Signature of Funeral Service Licensee Alyson K Taylor  |  | 22. Name and Address of Facility Cremation Society of Maryland Inc   |                                |  |  |  |   |
|  |  | 299 Frederick Road, Baltimore, Maryland 21228  |                                |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><i>Chronic obstructive pulmonary disease</i>  |                                |  |  | Approximate Interval Between Onset and Death   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | {<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |                                |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown        |                                |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Hospice</i> |                                |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |                                | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |
|  |  |  |                                |  |  |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number D 58303  |                                |  |  | 29d. Date signed (Month, Day, Year) May 10 2012  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |  |                                |  |  |  |   |
| <i>Aaron J. Utterback MD</i>   |  |  |                                |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature  |                                |  |  |  |   |

**Baltimore, Maryland 21215-0036**

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

**State  
Registrar**

20

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15415

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Marcus Snelling

2. Date of Death

Month

Day

Year

Mo

12

2012

2000

M

Time of Death

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Marcus Snelling

2. Date of Death

Month

Day

Year

Mo

12

2012

2000

M

Time of Death

3. Time of Death

4a. Facility Name (if not institution, give street and number)

5. Social Security Number

052-56-1376

Usual Residence of Decedent

6. Sex

 M F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

02 23 1961

NY

9. Birthplace (State or Foreign Country)

Baltimore

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10e. Street and Number

3822 Woodbine Ave

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

 Never Married Married Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

Unemployed

17. Father's Name (First, Middle, Last)

Julius Snelling

18. Mother's Name (First, Middle, Maiden Surname)

Judith Britton-Sister

19a. Informant's Name/Relationship (Type, Print)

Judith Britton-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Autumn Blaze Court, Woodstock, Md 21163

20a. Method of Disposition

 Burial Cremation Removal from State Donation Other (Specify)

King Memorial Park

5/17/2012

Woodlawn, Md

21. Signature of Funeral Service Licensee

► [Signature]

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

22. Name and Address of Facility

Approximate Interval Between Onset and Death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Multiple Organ Failure

Due to (or as a consequence of):

b. Metastatic Cancer

Due to (or as a consequence of):

c. Primary unknown.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

 Yes No Unknown

23c. If yes, outcome of pregnancy

 Live Birth Fetal death Ectopic pregnancy Pregnant at time of death Other (specify) Unknown

23d. Date of delivery

Month

Day

Year

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown

24a. Was an autopsy performed?

 Yes No

24b. Were autopsy findings available prior to completion of cause of death?

 Yes No

25. Was case referred to medical examiner?

 Yes No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

26. Place of Death (Check only one)

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

 Natural Accident Suicide Homicide Pending Investigation Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

1 Yes

2 No

28c. Injury at work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

 Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 only one Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

029085

29d. Date signed (Month, Day, Year)

Nov 12 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

► [Signature]

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

Suzanne J. Parker

DHMH 17 Rev 06-2011

ORIGINAL

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15416

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once, e.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Medical Certificate To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month <u>May</u> Day <u>09</u> Year <u>2012</u>  |  | 3. Time of Death<br><u>12:05 PM</u>  |
| <u>Kim Valarie Smith</u>  |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><u>Good Samaritan Hospital</u>  |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death  |
| 5. Social Security Number<br><u>217-66-6954</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><u>55</u> Yrs. | If Under 1 Year<br>Months <u>02</u> Days <u>27</u> Hours <u>57</u> Min.  |
| 10a. State<br><u>MD</u>   |  | 10b. County<br><u>NA</u>   |  | 10c. City, Town or Location<br><u>Baltimore</u>  |
| 10e. Street and Number<br><u>803 Lenton Ave Apt A</u>   |  | 10f. Zip Code<br><u>21212</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>Black</u> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><u>Elementary/Secondary (0-12) 12th grade</u>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><u>Certify Medical Assistant</u>   |  | 16b. Kind of Business/Industry<br><u>Holly Hill Manor</u>  |
| 17. Father's Name (First, Middle, Last)<br><u>Robert Butts</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Irene Shannon</u>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>India Joydan-Granddaughter</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>803 Lenton Ave Apt A, Baltimore, Md 21212</u>  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>On-Site</u>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>On-Site</u>   |  | Date <u>5/15/2012</u> 20c. Location - City or Town, State <u>Baltimore, Md</u>   |
| 21. Signature of Funeral Service Licensee<br><u>Slynn B. Kite</u>   |  | 22. Name and Address of Facility<br><u>March F/H West</u><br><u>4300 Wabash Ave, Baltimore, Md 21215</u>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><u>Cardiac arrest</u>   |  | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. Due to (or as a consequence of):<br><u>CAD</u>  |  |  |
| 23d. Date of delivery<br>Month <u>Day</u> <u>Year</u>   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown    |  | 23d. Date of delivery<br>Month <u>Day</u> <u>Year</u>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown           |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><u>D0664104</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>May 9, 2012</u>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Simin Sistani</u> <u>5601 Loch Raven Boulevard, Baltimore, MD 21219</u>  |  | 31. Date filed (Month, Day, Year)<br><u>MAY 15 2012</u>  |  | 32. Registrar's Signature<br><u>J. Parker</u>  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1 perpHYS, G927, 5/15/2012, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

15417

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

|   |  |   |                                |   |                                     |
|---|--|---|--------------------------------|---|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  |                                | 3. Time of Death  |                                     |
| <u>Mary E Snowden</u>   |  | Month <u>4</u>  | Day <u>27</u>                  | Year <u>12</u>  | Time <u>845 PM</u>                  |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                                | 4c. County of Death   |                                     |
| <u>MEDEVAC MEDICAL CENTER</u>   |  | <u>BALTIMORE</u>  |                                | <u>N/A</u>  |                                     |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year   | If Under 24 Hrs.                    |
| <u>212-60-4062</u>  |  | <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | <u>60</u> Yrs.                 | Months  | Days                                |
|   |  |   |                                | Hours   | Min.                                |
| 8. Date of Birth (Month, Day, Year)   |  | 9. Birthplace (State or Foreign Country)  |                                | 10d. Inside City Limits   |                                     |
| <u>3/26/1952</u>  |  | <u>VA</u>   |                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                     |
| 10a. State  |  | 10b. County   | 10c. City, Town or Location    |   |                                     |
| <u>MD</u>   |  | <u>N/A</u>  | <u>Baltimore</u>               |   |                                     |
| 10e. Street and Number  |  | 10f. Zip Code   |                                | 10g. Citizen of What Country?   |                                     |
| <u>3632 Lyndale Ave.</u>  |  | <u>21213</u>  |                                | <u>USA</u>  |                                     |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                     |
| <input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.        |                                | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                |                                     |
| 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |                                | 16b. Kind of Business Industry  |                                     |
| <u>Elementary/Secondary (0-12)<br/>12th</u>   |  | <u>College (1-4 or 5+)<br/>2 yrs.</u>   |                                | <u>Sams Club</u>  |                                     |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |   |                                     |
| <u>Glascoe Pope Sr.</u>   |  | <u>Alma Stephens</u>  |                                |   |                                     |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)             |                                |   |                                     |
| <u>Kimberly D. Snowden-Daugh</u>  |  | <u>3632 Lyndale Ave. Baltimore, MD 21213</u>  |                                |   |                                     |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                    |                                | Date  | 20c. Location - City or Town, State |
| <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | <u>King Memorial Pk.</u>  |                                | <u>5/7/2012</u>   | <u>Randallstown, MD</u>             |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |   |                                     |
| <u>► Lynette K. Jones</u>   |  | <u>March F/H-East 1101E.<br/>North Ave. Baltimore, MD 21202</u>   |                                |   |                                     |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |                          |  |                                   |
|---|--|---|--------------------------|--|-----------------------------------|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  | Approximate Interval Between Onset and Death  |                          |  |                                   |
| Immediate Cause (Final disease or condition resulting in death)   |  | <u>UNKNOWN</u>  |                          |  |                                   |
| a. Due to (or as a consequence of):<br><br><u>CORONARY ARTERY DISEASE</u>   |  |   |                          |  |                                   |
| b. Due to (or as a consequence of):   |  |   |                          |  |                                   |
| c. Due to (or as a consequence of):   |  |   |                          |  |                                   |
| d. _____  |  |   |                          |  |                                   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |                          |  |                                   |
| 23d. Date of delivery<br>Month Day Year   |  |   |                          |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                          |  |                                   |
|   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          |  |                                   |
|   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                          |  |                                   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                          |  |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                   |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><u>D64307</u>  |                          | 29d. Date signed (Month, Day, Year)<br><u>4/27/12</u>                            |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |                          |  |                                   |
| <u>DAVID A. VITBERG, MD 345 ST. PAUL PLACE BALTIMORE, MD 21201</u>  |  |   |                          |  |                                   |
| 31. Date filed (Month, Day, Year)   |  | 32. Registrar's Signature   |                          |  |                                   |
| <u>MAY 15 2012</u>  |  | <u>► Lynette K. Jones</u>   |                          |  |                                   |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15418

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ernestine Screeven

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |   | 3. Time of Death   |
| <b>Ernestine mae SCREVEN</b>   |  | May 11, 2012  |   | 10:55 AM   |
| 4a. Facility Name (if not institution, give street and number)<br><b>BALTIMORE WASHINGTON MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| 5. Social Security Number<br><b>140-40-0129</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>64</b><br>Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/13/1947</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  | If Under 1 Year<br>Months Days Hours Min.   |   | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |   | 10c. City, Town or Location<br><b>MILLERSVILLE</b>   |
| 10e. Street and Number<br><b>622 CRUCIBLE COURT</b>  |  | 10f. Zip Code<br><b>21108</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>2</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>BLACK</b> |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>LEGAL SECRETARY</b>   |
| 16b. Kind of Business Industry<br><b>LAW FIRM</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE JACKSON</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY PEYTON</b>  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY L. JACKSON /MOTHER</b>   |  | 19b. Mailing Address (Street and Number / Rural Route Number, City or Town, State, Zip Code)<br><b>622 CRUCIBLE CT., MILLERSVILLE, MARYLAND 21108</b>   |   | 19c. Date<br><b>05/19/2012</b>   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Rosedale Ceme.</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROSEDALE CEME.</b>   |   | 20c. Location - City or Town, State<br><b>MONTCLAIR, NEW JERSEY</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Derrick C. Jones</b>   |  | 22. Name and Address of Facility<br><b>THE DERRICK C. JONES FUNERAL HOME PARK Hgts. AVE., BALTIMORE, MARYLAND 21215</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death<br><b>metastatic Ovarian Cancer</b>  |   |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M                            | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>D48006</b>  |   |  |
| 29b. Signature and title of certifier<br><b>Derrick C. Jones MD</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>05/11/2012</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KDFJ OWNERS-BARTLEY, 301 Hospital Dr., Glen Burnie, MD</b>  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Susan J. Gaskin</b>   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

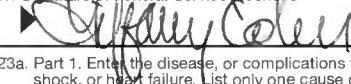
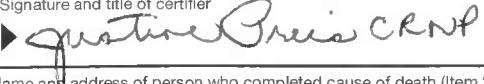
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15419

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|---|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Lila Louise Skalla</b>  |  |  |   |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>11</b> , Year <b>2012</b>  | 3. Time of Death<br><b>1:00 A.M.</b>   |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Stella Maris</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b> |  |  | 4c. County of Death<br><b>Baltimore</b>  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>543-30-9233</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.        |  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 30, 1931</b>  | 9. Birthplace (State or Foreign Country)<br><b>Oregon</b> |  |
|  | Usual Residence of Decedent<br><b>MD Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Severna Park</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>191 Grosvenor Lane</b>  |  |  |   | 10f. Zip Code<br><b>21146</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RN</b>   |  |  | 16b. Kind of Business/Industry<br><b>Hospital</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>W. Hensley Holt</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Mae Walters</b>   |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Greg Skalla-son</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1103 Corbett Road-Monkton, Maryland 21111</b>  |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Evans Funeral Chapel and Cremation Belair</b>  |   | Date<br><b>May 12, 2012</b>  | 20c. Location - City or Town, State<br><b>Forest Hill, Maryland</b>                            |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Evans Funeral Chapel and Cremation Services<br/>8800 Harford Road-Parkville, Maryland 21234</b>   |  |  |  |   |  |
| Physician/<br>Medical<br>Examiner                                  | <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> |  |  |   |  |  |  |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)       |   |  | 23d. Date of delivery<br>Month Day Year  |  | Approximate Interval Between Onset and Death   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M                                | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |  |   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician<br><input type="checkbox"/> Medical Examiner<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner  |  | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>R043580</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>05-11-2012</b>                                       |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JUSTINE PREIS, CRNP</b>   |  | 2300 DULANEY VALLEY ROAD   |   |  | TIMONIUM MD 21093  |  |  |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |   |  |

1:00 A.M.

Baltimore, Maryland 21215-0036

SKALLA  
Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15420

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**David Edmund Sumler**

2. Date of Death

Month  
**May**

Day  
**10**

Year  
**2012**

3. Time of Death

**3:50 PM**

4a. Facility Name (if not institution, give street and number)

**Union Memorial Hospital**

4b. City, Town, or Location of Death

**Baltimore**

4c. County of Death

**N/A**

Funeral  
Director

5. Social Security Number

**228-54-4990**

6. Sex

M  F

7. Age (In yrs. last birthday)

**70**

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

**Aug. 07, 1941**

9. Birthplace (State or Foreign Country)

**Washington, D.C.**

Usual Residence of Decedent

10a. State

**Maryland**

10b. County

**N/A**

10c. City, Town or Location

**Baltimore**

10d. Inside City Limits

Yes  No

10e. Street and Number

**1205 Havenwood Road**

10f. Zip Code

**21218**

10g. Citizen of What Country?

**United States**

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) **12** College (1-4 or 5+) **08**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**Assistant Secretary  
for Academics**

16b. Kind of Business/Industry

**State of Maryland**

17. Father's Name (First, Middle, Last)

**Joseph W. Sumler, Sr.**

18. Mother's Name (First, Middle, Maiden Surname)

**Theora Laduska Bullman**

19a. Informant's Name/Relationship (Type, Print)

**(Wife)  
Mrs. Claudia(nee Burnett)Sumler**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**1205 Havenwood Road Baltimore, Maryland 21218**

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Evans Funeral Chapel and  
Cremation Services, Inc.**

Date

**Sunday,  
May 13, 2012**

20c. Location - City or Town, State

**(Harford County)  
Forest Hill, Maryland**

21. Signature of Funeral Service Licensee

**Jeffrey L. Gair, Sr. OFSP**

Lic. #M00677

22. Name and Address of Facility

**Regional Alternatives Funeral and Cremation Center, P.A.  
2325 York Road Timonium, Maryland 21093-2215**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **anoxic brain injury**  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

**2 Days**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. **cardiac arrest**  
Due to (or as a consequence of):

**2 Days**

c. **coronary artery disease**  
Due to (or as a consequence of):

**2 Days**

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify) \_\_\_\_\_  
 Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?  
 Yes  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death  
 Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?  
 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

**Dave Bolger DO**

29c. License number

**AT2438946**

29d. Date signed (Month, Day, Year)

**5/10/12**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DAVE BOLGER, DO Union Memorial Hospital Baltimore, Maryland**

31. Date filed (Month, Day, Year)

**MAY 15 2012**

32. Registrar's signature

**David Sumler, Maryland 21215-0036**

Important: Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 1542

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)

James Russell Schmidt

2. Date of Death

Month  
May

Day  
12, 2012

Year  
12:35 AM

4a. Facility Name (if not institution, give street and number)

14752 Carriage Mill Road

4b. City, Town, or Location of Death

Woodbine

4c. County of Death

Howard

5. Social Security Number

149-52-8669

Usual Residence of Decedent

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months  
Yrs.

If Under 24 Hrs.

Days  
Hours  
Min.

8. Date of Birth

(Month, Day, Year)

June 14, 1956

9. Time of Death

12:35 AM

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

14752 Carriage Mill Road

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

VP, Director, Sales Marketing

16b. Kind of Business/Industry

Health Care Facility Management

17. Father's Name (First, Middle, Last)

James Alfred Schmidt

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Gertrude Bennett

19a. Informant's Name/Relationship (Type, Print)

Carol Ann Schmidt / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14752 Carriage Mill Rd. Woodbine, MD 21797

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Final Journey Crematory 5/14/2012

Woodbine, Maryland

21. Signature of Funeral Service Licensee

*Beverly L. Heckrotte*

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. *Adenocarcinoma of Gastro Esophageal*

5 months

Due to (or as a consequence of):

b. *Liver metastasis*

Due to (or as a consequence of):

c. *Bone metastasis*

Due to (or as a consequence of):

d. \_\_\_\_\_

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural

2  Accident

3  Suicide

4  Homicide

5  Pending Investigation

6  Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*GAYATRI MAMACADA*

29c. License number

D39041

29d. Date signed (Month, Day, Year)

May 14<sup>th</sup> 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAYATRI MAMACADA

5450 Knoll

COLUMBIA

MD 21045

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

*Leanne J. Gates*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15422

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68700

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

|  |  |  |   |   |
|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |   | 3. Time of Death  |
| Mary Schlaffer   |  | May 12, 2012   |   | 5:07 pM   |
| 4a. Facility Name (if not institution, give street and number)<br>Genesis Eldercare- Heritage Center   |  | 4b. City, Town, or Location of Death<br>Dundalk  |   | 4c. County of Death<br>Baltimore  |
| 5. Social Security Number<br>212-09-7466   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br>92 Yrs. | If Under 1 Year<br>Months Days Hours Min.   |
|  |  |  |   | 8. Date of Birth<br>(Month, Day, Year)<br>September 29, 1919  |
|  |  |  |   | 9. Birthplace (State or Foreign Country)<br>Maryland  |
| 10a. State<br>Md.  |  | 10b. County<br>Baltimore   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br>7610 Maple Road  |  | 10f. Zip Code<br>21222   |   | 10g. Citizen of What Country?<br>USA  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10 years  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |   | 16b. Kind of Business Industry<br>Banquet Waitress Hotel  |
| 17. Father's Name (First, Middle, Last)<br>Thomas Leo Martin   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella May Winkler  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>George C. Schlaffer Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1801 Monumental Road, Dundalk, Md. 21222  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oak Lawn Cemetery  |   | 20c. Location - City or Town, State<br>May 19, 2012 Baltimore, Maryland   |
| 21. Signature of Funeral Service Licensee<br>Anthony Connelly  |  | 22. Name and Address of Facility<br>Connelly Funeral Home of Dundalk, P.A.<br>7110 Sollers Point Road, Dundalk, Md. 21222  |   | Approximate Interval Between<br>Death and Death<br>3 days.  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br>PNEUMONIA   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24 YEARS  |   |   |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |
| 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23g. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 23h. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D14160  |   | 29d. Date signed (Month, Day, Year)<br>MAY 13, 2012   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>HAROLD SINGH MD 310-A RITCHIE HIGHWAY,<br>BALTIMORE, MARYLAND - 21225  |  | 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |   | 32. Registrar's Signature<br>John J. Price  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15423

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMH 17 Rev 06-2011

|          |  |  |  |   |  |   |  |  |  |  |  |  |  |
|----------|--|--|--|---|--|---|--|--|--|--|--|--|--|
|          |  | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Sevick</b>   |  |   |  |   |  | 2. Date of Death<br><b>May 10 2012</b>   |  | 3. Time of Death<br><b>10:30 PM</b>  |  |  |  |
|          |  | 4a. Facility Name (if not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b> |   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |  |  |  |  |
|          |  | 5. Social Security Number<br><b>212-32-7161</b>  |  | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>75 Yrs.</b>           | If Under 1 Year<br>Months   |  | If Under 24 Hrs.<br>Hours  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 24, 1936</b>             |  |  |  |
|          |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>   |  |  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                |  |  |  |
|          |  | 10e. Street and Number<br><b>192 Plymouth Lane Apt. F</b>  |  |   |  | 10f. Zip Code<br><b>21061</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>                      |  |  |  |
|          |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>12</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |  |  |
|          |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Draftsman</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>NSA</b>                               |  |  |  |
|          |  | 17. Father's Name (First, Middle, Last)<br><b>Paul Sevick</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara A. Wagner</b>   |  |  |  |  |  |  |  |
|          |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Robert S. Sevick / Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7124 Harlan Lane Sykesville, MD 21784</b>   |  |  |  |  |  |  |  |
|          |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>20b. Place of Disposition (Name of cemetery, crematory or other place)<br/>Atlantic Crematory</b>  |  |   |  | Date<br><b>05/16/2012</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>  |  |  |  |  |  |
|          |  | 21. Signature of Funeral Service Licensee<br><b>R. S. Sevick</b> M01121  |  |   |  | 22. Name and Address of Facility<br><b>Singleton Funeral &amp; Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061</b>   |  |  |  |  |  |  |  |
|          |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Stroke</b>  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b>             |  |  |  |
|          |  | <p>a. Due to (or as a consequence of):<br/> <b>Stroke</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |  |   |  |  |  |  |  |  |  |
|          |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
|          |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disease</b><br><b>acute renal failure</b>   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |  |  |
|          |  |  |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|          |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | Hospital:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A  |  | Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26. Place of Death (Check only one)  |  |  |  |  |  |
|          |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
|          |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>   |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Glen Burnie, MD 21061</b>   |  |  |  |  |  |
|          |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  | 29c. License number<br><b>D68240</b>                                       |  |  |  |
|          |  | 29b. Signature and title of certifier<br><b>Vadim Korkhov, MD</b>  |  |   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 11 2012</b>  |  |  |  |  |  |
|          |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vadim Korkhov 301 Hospital Drive, Glen Burnie, MD 21061</b>   |  |   |  |   |  |  |  |  |  |  |  |
|          |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Leanne S. Parker</b>  |  |   |  |  |  |  |  |  |  |
| ORIGINAL |  |  |  |   |  |   |  |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15424

1 - For  
State  
Registrar**Physician/  
Medical  
Examiner****Funeral  
Director**

To Be Completed by Funeral Director

|   |  |   |   |   |   |  |   |  |
|---|--|---|---|---|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death  |   |   |  | 3. Time of Death  |  |
| Mildred Elizabeth Seabolt   |  |   | Month May   |   | Day 10, 2012  |  | 9:00 PM   |  |
| 4a. Facility Name (if not institution, give street and number)  |  |   | 4b. City, Town, or Location of Death  |   |   |  | 4c. County of Death                                       |  |
| Montgomery Hospice Casey House  |  |   | Rockville   |   |   |  | Montgomery  |  |
| 5. Social Security Number<br>579-34-4588  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>87 Yrs.   |   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br>April 8, 1925   | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.     |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Gaithersburg |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br>403 West Diamond Avenue, # T-1  |  |   | 10f. Zip Code<br>20877  |   |   |  | 10g. Citizen of What Country?<br>United States            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Assembly Person                   |   |   |  | 16b. Kind of Business/Industry<br>Electronics             |  |
| 17. Father's Name (First, Middle, Last)<br>William Lowe   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mildred (Unknown)  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Thomas L. Finley /Son   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13202 Gerlach Court, Mt. Airy, Maryland 21771    |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |   |   | Date<br>May 15, 2012   | 20c. Location - City or Town, State<br>Suitland, Maryland |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br>300 West Montgomery Avenue, Rockville, Maryland 20850-2805 |   |   |  |   |  |

**Physician/  
Medical  
Examiner**

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |   |  |  |   |                                   |  |
|--|--|---|--|--|---|--|--|---|-----------------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Signature of Funeral Service Licensee<br> |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year   |                                   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 23f. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No              |  |  | 23g. Hospital:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |  |  | 23h. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                   |  |
| 23i. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined   |  | 23j. Date of injury (Month, Day, Year)  |  |  | 23k. Time of injury<br>M  |  | 23l. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 23m. Describe how injury occurred |  |
| 23n. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |   |  |  | 23o. Location (Street and Number or Rural Route Number, City or Town, State)  |                                   |  |
| 23p. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |  |  |   |                                   |  |
| 23q. Signature and title of certifier<br>   |  |   |  |  | 23r. License number<br>D0060634   |  |  | 23s. Date signed (Month, Day, Year)<br>May 11, 2012   |                                   |  |
| 23t. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Bindu Joseph, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855  |  |   |  |  |   |  |  |   |                                   |  |
| 23u. Date filed (Month, Day, Year)<br>MAY 15 2012  |  | 23v. Registrar's Signature<br>               |  |  |   |  |  |   |                                   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

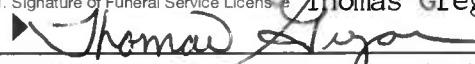
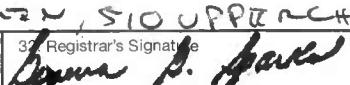
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15425  
Certificate of Death Reg. No.

1 - For  
State  
Registrar

|  |   |  |   |                           |   |   |   |  |   |
|--|---|--|---|---------------------------|---|---|---|--|---|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Douglas Scott Thropp III</b>   |  |   |                           |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>15</b> Year  | 3. Time of Death<br>3:12 a M                                    |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>1715 Church Point Court</b>  |  |   |                           | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>   |   |   | 4c. County of Death<br><b>Harford</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>130-38-0697</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec 13, 1950</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |   |
|  | 10a. State <b>Maryland</b> 10b. County <b>Harford</b>   |  |   |                           | 10c. City, Town or Location<br><b>Aberdeen</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>1715 Church Point Court</b>  |  |   |                           | 10f. Zip Code<br><b>21001</b>   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.       |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>President Of Corporation</b>  |   |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Douglas Scott Thropp II</b>   |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evlynn Carter</b>   |   |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Peggy L. Thropp, Wife</b>  |  |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1715 Church Point Court Aberdeen, MD 21001</b>  |   |   |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc.</b>   |   | Date<br><b>05/15/12</b>                                     | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |                           | 22. Name and Address of Facility<br><b>Cremation Society Of Maryland, Inc.</b><br><b>299 Frederick Road Baltimore, Maryland 21228</b>   |   |   |  |   |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (isease or injury that initiated events resulting in death) Last   |  |   |                           |   |   |   |  | Approximate Interval Between Onset and Death<br><b>27 years</b> |
|  | <p>a. Due to (or as a consequence of):<br/><b>BLADDER CANCER</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |  |   |                           |   |   |   |  |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |   |                           | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year                         |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                           | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |   |
|  |   |  |   |                           | <p>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                               |   |   |  |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA |                           |   | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |                           | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                           |  |   |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>00058475</b>  |                           | 29d. Date signed (Month, Day, Year)<br><b>MAY 15, 2012</b>  |   |   |  |   |
|  | 29b. Signature and title of certifier<br>  |  |   |                           |   |   |   |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PHILIP NATALE, 510 UPPERNCHESAPEAKE DR, BALTIMORE, MD 21204</b>  |  |   |                           |   |   |   |  |   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  | 32. Registrar's Signature<br>  |                           |   |   |   |  |   |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

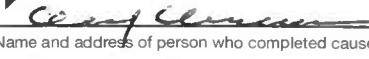
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No.

2012 15426

|  |  |   |   |  |   |  |                                |  |  |   |                     |  |      |  |  |
|--|--|---|---|--|---|--|--------------------------------|--|--|---|---------------------|--|------|--|--|
| For<br>State<br>Registrar  |  | State of Maryland / Department of Health and Mental Hygiene   |   |  |   |  |                                | Certificate of Death   |  |   | Reg. No.            | 2012   | 1542 |  |  |
| 1. Decedent's Name (First, Middle, Last)   |  |   |   |  |   |  |                                | 2. Date of Death<br>Month Day Year   |  |   | 3. Time of Death    |  |      |  |  |
| Terry Taylor   |  |   |   |  |   |  |                                | Aug 9 2012   |  |   | 3:20 AM             |  |      |  |  |
| 4a. Facility Name (if not institution, give street and number)   |  |   |   |  |   |  |                                | 4b. City, Town, or Location of Death   |  |   | 4c. County of Death |  |      |  |  |
| 5. Social Security Number<br>214-56-6363   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>62 Yrs. | If Under 1 Year<br>Months Days   |   |  | If Under 24 Hrs.<br>Hours Min. |  |  | 8. Date of Birth<br>(Month, Day, Year)<br>3-17-1950 |                     | 9. Birthplace (State or Foreign Country)<br>PA   |      |  |  |
| Usual Residence of Decedent  |  | 10a. State<br>MD  |   | 10b. County<br>Baltimore   |   | 10c. City, Town or Location<br>Windsor Mill  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |                     |  |      |  |  |
| 10e. Street and Number<br>8 Deer Glen Court  |  |   |   | 10f. Zip Code<br>21244   |   |  |                                | 10g. Citizen of What Country?<br>USA   |  |   |                     |  |      |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: African-American                    |  |   |                     |  |      |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5+   |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life, DO NOT use retired)<br>Lobbyist                   |   |  |                                | 16b. Kind of Business/Industry<br>People's Community Health Center                             |  |   |                     |  |      |  |  |
| 17. Father's Name (First, Middle, Last)<br>Melvin W. Taylor  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosalie Johnson  |  |                                |  |  |   |                     |  |      |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marissa Taylor/ Wife   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8 Deer Glen Court, Windsor Mill, MD 21244 |   |  |                                |  |  |   |                     |  |      |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory  |   |  | Date<br>5-15-2012              |  | 20c. Location - City or Town, State<br>Baltimore, MD |   |                     |  |      |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br>Wylie Funeral Home P.A. of Baltimore Co.<br>9200 Liberty Road, Randallstown, MD 21133                  |   |  |                                |  |  |   |                     |  |      |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |   |  |   |  |                                |  |  |   |                     | Approximate Interval Between Onset and Death   |      |  |  |
| <p>a. Ventricular tachycardia<br/>Due to (or as a consequence of):</p> <p>b. Severe cardiovascular; myocardial infarction<br/>Due to (or as a consequence of):</p> <p>c. Hypertension<br/>Due to (or as a consequence of):</p> <p>d.</p>   |  |   |   |  |   |  |                                |  |  |   |                     |  |      |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  |   |  |                                |  |  | 23d. Date of delivery<br>Month Day Year             |                     |  |      |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cardinal vascular accident<br>Final stage renal disease  |  |   |   |  |   |  |                                |  |  |   |                     | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |      |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                |  |  |   |                     |  |      |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                | 28d. Describe how injury occurred  |  |   |                     |  |      |  |  |
|  |  |   |   |  |   |  |                                |  |  |   |                     |  |      |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |   |                     |  |      |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   |  |   | 29c. License number<br>029085  |                                | 29d. Date signed (Month, Day, Year)<br>Aug 9 2012  |  |   |                     |  |      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Allen J. Charles 5401 Old Court Road<br>21183  |  |   |   |  |   |  |                                |  |  |   |                     |  |      |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>  |   |  |   |  |                                |  |  |   |                     |  |      |  |  |

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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## **Physician/ Medical Examiner**

**Funeral  
Director**

## To Be Completed by Funeral Director

## **Physician/ Medical Examiner**

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68/60

State  
Registrar



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15428

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

|  |  |   |  |  |  |   |   |   |  |  |  |
|--|--|---|--|--|--|---|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>SARAH A TABB</b>  |  |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 4 2012</b> |   |  | 3. Time of Death<br>11:45 AM   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Overlea Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |   | 4c. County of Death<br><b>N/A</b>                           |  |  |  |
| 5. Social Security Number<br><b>226-62-0329</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69 Yrs.</b>   |  | If Under 1 Year<br>Months Days Hours Min.                               |   | 8. Date of Birth<br>(Month, Day, Year)<br><b>12/26/1942</b> |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6116 Belair Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21206</b>  |  |   |   | 10g. Citizen of What Country?<br><b>USA</b>                 |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |   |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11th</b>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>N/A</b>  |  |   |   | 16b. Kind of Business/Industry<br><b>Waitress</b>           |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William S. Jarris</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah E. Jones</b>   |  |   |   |   |  |  |  |

|   |  |  |  |  |
|---|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosemary Williams-Sister</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5200 Bowleys Lane #205 Balt., MD 21206</b> |  |  |
|---|--|--|--|--|

|   |  |   |  |                          |   |
|---|--|---|--|--------------------------|---|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mt. Carmel Cemt.</b> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Carmel Cemt.</b> |  | Date<br><b>5/11/2012</b> | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |
|---|--|---|--|--------------------------|---|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 21. Signature of Funeral Service Licensee<br><b>Brandi McLean</b> |  | 22. Name and Address of Facility<br><b>March F/H-East 1101 E. North Ave. Baltimore, MD 21202</b> |  |  |  |
|---|--|--|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | Approximate Interval Between Onset and Death<br><b>30 minutes</b> |  |  |  |
| a. Due to (or as a consequence of):<br><b>CARDIAC ARRHYTHMIA</b>   |  |   |  |  |  |
| b. Due to (or as a consequence of):<br><b>Hypertensive heart disease</b>   |  | <b>1042</b>   |  |  |  |
| c. Due to (or as a consequence of):<br><b>Hypertension</b>   |  | <b>15425</b>  |  |  |  |
| d. Due to (or as a consequence of):<br><b>Diabetes mellitus</b>  |  | <b>11</b>   |  |  |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year |  |
|--|--|---|--|--|--|---|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Osteoporosis</b> |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|---|--|--|--|--|--|

|  |  |  |  |                          |  |   |  |  |  |
|--|--|--|--|--------------------------|--|---|--|--|--|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |  |  |  |                          |  |   |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |                          |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

|   |  |                                      |  |  |  |  |  |
|---|--|--------------------------------------|--|--|--|--|--|
| 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Only one (1) box may be checked. |  | 29c. License number<br><b>D30494</b> |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5-8-2012</b> |  |
|---|--|--------------------------------------|--|--|--|--|--|

|   |  |  |  |                                      |  |  |  |
|---|--|--|--|--------------------------------------|--|--|--|
| 29b. Signature and title of certifier<br><b>Desai</b> |  |  |  | 29c. License number<br><b>D30494</b> |  |  |  |
|---|--|--|--|--------------------------------------|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K DESAI MD die maiden choice lane 302 Baltimore MD 21228</b> |  |  |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> |  | 32. Registrar's Signature<br><b>Leanne P. Parker</b> |  |
|---|--|--|--|

amend items 20b,c per fh g927 5-21-12 vt  
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 28a per me g927 5-17-12 vt

State of Maryland / Department of Health and Mental Hygiene 2012 15429  
Amend Items 28a-f per me, g927 05/11/2012 dbb Certificate of Death Reg. No.

1- For State Registrar

|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
|---|--|--|---------------------------|---|--|--|---|--|--|--|---|--|--|---|--|
| Physician /Medical Examiner                   |  | 1. Decedent's Name (First, Middle, Last)   |                           |   |  |  |   | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death<br>Hour:Minute AM/PM  |   |  |  |   |  |
|   |  | <i>Corinthia A. Tate</i>   |                           |   |  |  |   | Apr 1 30 2012  |  | 02:27 AM   |   |  |  |   |  |
| Funeral Director                              |  | 4a. Facility Name (If not institution, give street and number)   |                           |   | 4b. City, Town, or Location of Death   |  |   | 4c. County of Death  |  |  |   |  |  |   |  |
|   |  | <i>Bon Secours Hospital</i>  |                           |   | <i>Baltimore</i>   |  |   | <i>N/A</i>   |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>61</i> Yrs.   |  | If Under 1 Year<br>Months Days Hours Min. |  | 8. Date of Birth<br>(Month, Day, Year)<br><i>Mar 15 1951</i> |  | 9. Birthplace (State or Foreign Country)<br><i>MD</i> |  |  |   |  |
|   |  | <i>214 56 4467</i>   |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director           |  | Usual Residence of Decedent  |                           |   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |   |  |
|   |  | 10a. State<br><i>MD</i>  | 10b. County<br><i>N/A</i> | 10c. City, Town or Location<br><i>Baltimore</i>   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director           |  | 10e. Street and Number<br><i>1014 N. Bentallou St.</i>   |                           |   | 10f. Zip Code<br><i>21216</i>  |  |   | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |   |  |  |   |  |
|   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><i>If Yes, Give Year or Dates:</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i>Specify: Black</i> |   | 14. Race - American Indian, Black, White, etc.   |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>11th</i>  |                           |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Child Care Provider</i> |  |   | 16b. Kind of Business/Industry<br><i>Child Care</i>  |  |  |   |  |  |   |  |
|   |  | 17. Father's Name (First, Middle, Last)<br><i>James Harris</i>   |                           |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Anna Colbert</i>   |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Ronnise Davenport - daughter</i>  |                           |   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1649 Appleton St. Baltimore MD 21217</i>   |  |  |   |  |  |   |  |
|   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>[Signature]</i>  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Western Star Cemetery</i>                                     |  |   | Date<br><i>5-5-12</i>  |  | 20c. Location - City or Town, State<br><i>Baltimore Catonsville, MD</i>  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |                           |   |  |  |   | 22. Name and Address of Facility<br><i>Gary P. March FH 270 Fred Hilton Pass Baltimore MD 21229</i>  |  |  |   |  |  |   |  |
|   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Acute myocardial infarction</i>  |                           |   |  |  |   | Approximate Interval Between Onset and Death<br><i>1 hr</i>  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Acute blood loss / exsanguination</i>  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
|   |  | {<br>a. Due to (or as a consequence of):<br><i>Acute myocardial infarction</i><br>b. Due to (or as a consequence of):<br><i>Acute blood loss / exsanguination</i><br>c. Due to (or as a consequence of):<br><i>Exsanguination</i><br>d. Due to (or as a consequence of):<br><i>Exsanguination</i>  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |                           | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>End stage renal disease</i><br><i>Hypertension</i>  |                           |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                           | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><i>Home</i>       |  |  |   |  |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |                           | 28a. Date of Injury<br>(Month, Day, Year)<br><i>04/20/2012</i>  |  | 28b. Time of Injury<br>Injury<br><i>1:00a.</i>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>Home</i>  |                           |   |  |  |   | 24a. Describe how injury occurred<br><i>Dislodged dialysis shunt.</i>  |  |  |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                           |   |  |  |   | 29c. License number<br><i>D0056240</i>   |  |  |   |  |  | 29d. Date signed (Month, Day, Year)<br><i>4/30/12</i> |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Marcia Cort, MD Bon Secours Hospital 200 W. Baltimore Street, Baltimore MD 21223</i>  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
|   |  |  |                           |   |  |  |   |  |  |  |   |  |  |   |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><i>MAY 11 2012</i>  |                           | 32. Registrar's Signature<br><i>Laura J. Parker</i>   |  |  |   |  |  |  |   |  |  |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15430

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
 permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
|  |  | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death<br>M  |  |
|  |  | LOUISE THOMAS  |  | May 11 2012   |  | 6:05 p M   |  |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death   |  |  |  |
| GOOD SAMARITAN NURSING CENTER  |  | BALTIMORE  |  | N/A   |  |  |  |
| 5. Social Security Number  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>90 Yrs.   |  | If Under 1 Year<br>Months Days Hours Min.  |  |
| 219-22-5787<br>Usual Residence of Decedent   |  |  |  |   |  |  |  |
| 10a. State<br>MARYLAND   |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>BALTIMORE  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br>6225 YORK ROAD APT 406   |  |  |  | 10f. Zip Code<br>21212  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                               |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12yrs   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |  | 16b. Kind of Business/Industry<br>LIBRARIAN   |  | CITY OF NEW YORK   |  |
| 17. Father's Name (First, Middle, Last)<br>LEONARD COOPER  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>HELEN G. JONES   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Bernadine Harrison/Sister  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1231 Walker Ave., Baltimore, Maryland 21239   |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>KING MEMORIAL PARK   |  | Date<br>05-18-2012  |  | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND                                     |  |
| 21. Signature of Funeral Service Person<br>  |  | 22. Name and Address of Facility<br>WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.<br>1206 W NORTH AVENUE   |  |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><i>Alzheimer's dementia</i>   |  |   |  | Approximate Interval Between Onset and Death<br>2010   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |
| 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Describe how injury occurred  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D28987   |  | 29d. Date signed (Month, Day, Year)<br>5/14/2010   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTO, MD 21239   |  | 31. Date filed (Month, Day, Year) MAY 15 2012  |  | 32. Registrar's Signature<br>   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15431

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |   |                          |   |
|---|--|---|--------------------------|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month<br>May  |                          | 3. Time of Death<br>Day<br>12, Year<br>2012<br>11:08 P M  |
| Nancy Ann VanGelder   |  | 4b. City, Town, or Location of Death<br>Westminster   |                          | 4c. County of Death<br>Carroll  |
| 4a. Facility Name (If not institution, give street and number)<br>Dove House  |  | 5. Social Security Number<br>193-34-0308  |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F<br>7. Age (In yrs. last birthday)<br>68 Yrs.   |
| 8. Date of Birth<br>(Month, Day, Year)<br>Nov 2, 1943   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 10a. State<br>MD  |  | 10b. County<br>Carroll  |                          | 10c. City, Town or Location<br>Hampstead  |
| 10e. Street and Number<br>5013 Millers Station Road   |  | 10f. Zip Code<br>21074  |                          | 10g. Citizen of What Country?<br>United States  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:<br>White |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Agent  |                          | 16b. Kind of Business/Industry<br>Real Estate   |
| 17. Father's Name (First, Middle, Last)<br>Robert Edwards   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Adkins  |                          |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Melissa Morrison / Daughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3215 Atlee Ridge Road New Windsor, MD 21776  |                          |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>► Beverly L. Heckrotte   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Final Journey Crematory 5/15/2012   |                          | 20c. Date<br>Date<br>20. Location - City or Town, State<br>Woodbine, Maryland   |
| 21. Signature of Funeral Service Licensee<br>► Beverly L. Heckrotte   |  | 22. Name and Address of Facility<br>Going Home Cremation Service P.O. Box 784<br>Beverly L. Heckrotte, P.A. Clarksville, MD 21029   |                          |   |
| 23a. Part 1. Enter the disease, or complications that caused the death, not enter the cause of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death, not enter the cause of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |                          | Approximate Interval Between Onset and Death  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown                         |                          |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year   |                          |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |                          |   |
|   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br>INPATIENT HOSPICE |                          |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28d. Describe how injury occurred   |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>D35398   |                          | 29d. Date signed (Month, Day, Year)<br>S-12-17  |
| 29b. Signature and title of certifier<br>► Flavio Ruster MD   |  | 29c. License number<br>D35398   |                          | 29d. Date signed (Month, Day, Year)<br>S-12-17  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Flavio Ruster, M.D. 555 S. Center St. Westminster MD 21157  |  | 31. Date filed (Month, Day, Year)<br>MAY 15 2012  |                          | 32. Registrar's Signature<br>Laura S. Parks   |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death****Funeral Director**

Reg. No.

2012 15432

**1- For State Registrar****Physician Medical Examiner**

|   |  |  |  |  |  |                                   |
|---|--|--|--|--|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Reginald Werrell, Jr.</b>                            |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 4, 2012</b> | 3. Time of Death<br>2201 hrs      |
| 4a. Facility Name (if not institution, give street and number)<br><b>1918 West Fairmount Avenue</b> |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |  |  | 4c. County of Death<br><b>N/A</b> |

|   |  |   |  |   |   |   |
|---|--|---|--|---|---|---|
| 5. Social Security Number<br><b>220-86-0233</b> | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>35</b> | If Under 1 Year<br>Months<br><b>Yrs.</b> | If Under 24 Hrs.<br>Days<br><b>Hours Min.</b> | 8. Date of Birth (MM/DD/YYYY)<br><b>July 22, 1975</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|---|--|---|--|---|---|---|

|                               |                           |   |  |  |  |  |
|-------------------------------|---------------------------|---|--|--|--|--|
| Usual Residence of Decedent   |                           |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10a. State<br><b>Maryland</b> | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b> |  |  |  |  |

|   |  |  |                               |   |  |  |
|---|--|--|-------------------------------|---|--|--|
| 10e. Street and Number<br><b>1918 West Fairmount Avenue</b> |  |  | 10f. Zip Code<br><b>21223</b> | 10g. Citizen of What Country?<br><b>USA</b> |  |  |
|---|--|--|-------------------------------|---|--|--|

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>1</b> <input type="checkbox"/> <b>2</b> | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>1</b> <input type="checkbox"/> <b>2</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>1</b> <input type="checkbox"/> <b>2</b> | 14. Race - American Indian, Black, White, etc.<br><b>Black</b><br>Specify: |
|--|--|--|--|

|  |   |  |
|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10th grade</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Care Provider</b> | 16b. Kind of Business/Industry<br><b>Baltimore City Health Dept.</b> |
|--|---|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Reginald Werrell, Sr.</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angela Forrester</b> |
|---|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jalaina Wright/ Sister</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3309 Royce Ave Baltimore, Maryland 21215</b> |
|---|--|

|   |  |                        |   |
|---|--|------------------------|---|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>1</b> <input type="checkbox"/> <b>2</b> <input type="checkbox"/> <b>3</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b> | Date<br><b>5/18/12</b> | 20c. Location - City or Town, State<br><b>Catonsville, MD</b> |
|---|--|------------------------|---|

|  |  |  |
|--|--|--|
| Signature of Funeral Service Licensee<br><i>Carrie Sherr</i> |  | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home</b> |
|--|--|--|

|  |  |   |
|--|--|---|
|  |  | 15240 Reisterstown Rd Baltimore, MD 21215 |
|--|--|---|

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 2a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

12-03470

Reginald Worrell, Jr.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death****Funeral Director**

|   |  |  |  |  |  |                                   |
|---|--|--|--|--|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Reginald Werrell, Jr.</b>                            |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 4, 2012</b> | 3. Time of Death<br>2201 hrs      |
| 4a. Facility Name (if not institution, give street and number)<br><b>1918 West Fairmount Avenue</b> |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |  |  | 4c. County of Death<br><b>N/A</b> |

|   |  |   |  |   |   |   |
|---|--|---|--|---|---|---|
| 5. Social Security Number<br><b>220-86-0233</b> | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>35</b> | If Under 1 Year<br>Months<br><b>Yrs.</b> | If Under 24 Hrs.<br>Days<br><b>Hours Min.</b> | 8. Date of Birth (MM/DD/YYYY)<br><b>July 22, 1975</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|---|--|---|--|---|---|---|

|                               |                           |   |  |  |  |  |
|-------------------------------|---------------------------|---|--|--|--|--|
| Usual Residence of Decedent   |                           |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10a. State<br><b>Maryland</b> | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b> |  |  |  |  |

|   |  |  |                               |   |  |  |
|---|--|--|-------------------------------|---|--|--|
| 10e. Street and Number<br><b>1918 West Fairmount Avenue</b> |  |  | 10f. Zip Code<br><b>21223</b> | 10g. Citizen of What Country?<br><b>USA</b> |  |  |
|---|--|--|-------------------------------|---|--|--|

|  |  |  |  |
|--|--|--|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>1</b> <input type="checkbox"/> <b>2</b> | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>1</b> <input type="checkbox"/> <b>2</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>1</b> <input type="checkbox"/> <b>2</b> | 14. Race - American Indian, Black, White, etc.<br><b>Black</b><br>Specify: |
|--|--|--|--|

|  |   |  |
|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10th grade</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Care Provider</b> | 16b. Kind of Business/Industry<br><b>Baltimore City Health Dept.</b> |
|--|---|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Reginald Werrell, Sr.</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angela Forrester</b> |
|---|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jalaina Wright/ Sister</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3309 Royce Ave Baltimore, Maryland 21215</b> |
|---|--|

|   |  |                        |   |
|---|--|------------------------|---|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>1</b> <input type="checkbox"/> <b>2</b> <input type="checkbox"/> <b>3</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b> | Date<br><b>5/18/12</b> | 20c. Location - City or Town, State<br><b>Catonsville, MD</b> |
|---|--|------------------------|---|

|  |  |  |
|--|--|--|
| Signature of Funeral Service Licensee<br><i>Carrie Sherr</i> |  | 22. Name and Address of Facility<br><b>Chatman-Harris Funeral Home</b> |
|--|--|--|

|  |  |   |
|--|--|---|
|  |  | 15240 Reisterstown Rd Baltimore, MD 21215 |
|--|--|---|

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State Registrar**

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><i>Donna M. Vincenti, MD</i> |
|---|---|

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15433

**Physician/  
Medical Examiner**1- For State  
Registrar

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1104 hrs |
| John Randolph Wright                     | May 9, 2012                        |                              |

**Funeral  
Director**

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 4a. Facility Name (if not institution, give street and number)<br>801 Hoods Mill Road | 4b. City, Town, or Location of Death<br>Taneytown                              | 4c. County of Death<br>Carroll            |   |   |  |
| 5. Social Security Number<br>220-54-9300  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>60 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>10/19/1951 | 9. Birthplace (State or Foreign Country)<br>MD |

|                  |                        |  |  |
|------------------|------------------------|--|--|
| 10a. State<br>MD | 10b. County<br>Carroll | 10c. City, Town or Location<br>Taneytown | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|------------------|------------------------|--|--|

|   |                        |                                      |
|---|------------------------|--------------------------------------|
| 10e. Street and Number<br>801 Hoods Mill Road | 10f. Zip Code<br>21787 | 10g. Citizen of What Country?<br>USA |
|---|------------------------|--------------------------------------|

|  |  |   |  |
|--|--|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: White | 14. Race - American Indian, Black, White, etc. |
|--|--|---|--|

|   |  |   |
|---|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Union Electrician | 16b. Kind of Business/Industry<br>IDEW - Local 24 |
|---|--|---|

|  |   |
|--|---|
| 17. Father's Name (First, Middle, Last)<br>Thomas Randolph Wright      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Ann Lovett   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Casey Wright / son | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>619 Country Club Road Red Lion, Pennsylvania 17356 |

|   |   |                    |  |
|---|---|--------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>Stephanie Custer</i> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. | Date<br>05/11/2012 | 20c. Location - City or Town, State<br>Baltimore, Maryland |
|---|---|--------------------|--|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br><i>Dedra Custer</i> | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, Maryland 21228 |
|--|---|

**Physician  
/Medical  
Examiner****Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|  |  |  |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | a. <b>Chronic Alcohol Abuse complicating Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|--|--|

|  |  |
|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |
|--|--|

|  |
|--|
| c.<br>Due to (or as a consequence of): |
|--|

|  |
|--|
| d.<br>Due to (or as a consequence of): |
|--|

|                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED |
|-----------------------------------|----------------------------------|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|       |   |  |
|-------|---|--|
| _____ | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|-------|---|--|

|   |  |   |
|---|--|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene |
|---|--|---|

|  |  |                     |  |                                   |
|--|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

|  |
|--|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|--|

|  |                                 |   |
|--|---------------------------------|---|
| 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 10, 2012 |
|--|---------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><i>Leanne A. Parker</i> |
|---|--|

**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15434

Reg. No.

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |                                    |  |  |  |                  |
|--|------------------------------------|--|--|--|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year |  |  |  | 3. Time of Death |
| <b>Esther Waynick</b>                    | <b>MAY 14 2012</b>                 |  |  |  | <b>5:11P M</b>   |

|  |                                      |  |  |  |                     |
|--|--------------------------------------|--|--|--|---------------------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death |  |  |  | 4c. County of Death |
| <b>Baltimore Washington Medical CENTER</b>                     | <b>Glen Burnie</b>                   |  |  |  | <b>Anne Arundel</b> |

|                           |   |                                |  |                     |  |  |  |
|---------------------------|---|--------------------------------|--|---------------------|--|--|--|
| 5. Social Security Number | 6. Sex  | 7. Age (In yrs. last birthday) | 8. Date of Birth<br>(Month, Day, Year) |                     |  |  | 9. Birthplace (State or Foreign Country) |
| <b>186-22-2186</b>        | <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | <b>83 Yrs.</b>                 | <b>Sept. 21, 1928</b>                  | <b>Pennsylvania</b> |  |  |  |

|                 |                     |                             |  |  |  |  |
|-----------------|---------------------|-----------------------------|--|--|--|--|
| 10a. State      | 10b. County         | 10c. City, Town or Location | 10d. Inside City Limits  |  |  |  |
| <b>Maryland</b> | <b>Anne Arundel</b> | <b>Glen Burnie</b>          | <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |  |  |  |

|                         |               |                               |
|-------------------------|---------------|-------------------------------|
| 10e. Street and Number  | 10f. Zip Code | 10g. Citizen of What Country? |
| <b>304 Milton Court</b> | <b>21061</b>  | <b>USA</b>                    |

|                    |   |  |   |
|--------------------|---|--|---|
| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |
|--------------------|---|--|---|

|  |  |                                |
|--|--|--------------------------------|
| 15. Decedent's Education<br>(Specify only highest grade completed) | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| <b>Elementary/Secondary (0-12) 10</b>                              | <b>Inspector</b>   | <b>Westinghouse</b>            |

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
| <b>Aben Gray</b>                        | <b>Violet Heakins</b>                             |

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| <b>Kathleen Hill / daughter</b>                  | <b>304 Milton Court Glen Burnie, Maryland 21061</b>   |

|   |  |                  |                                     |
|---|--|------------------|-------------------------------------|
| 20a. Method of Disposition  | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date             | 20c. Location - City or Town, State |
| <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b> | <b>Metro Crematory, Inc.</b>   | <b>5/15/2012</b> | <b>Baltimore, Maryland</b>          |

|   |                  |   |                                     |
|---|------------------|---|-------------------------------------|
| 21. Signature of Funeral Service Licensee | Stephanie Custer | 22. Name and Address of Facility                    | Cremation Society of Maryland, Inc. |
|   |                  | <b>299 Frederick Road Baltimore, Maryland 21228</b> |                                     |

|  |  |  |  |
|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death |  |  |
| a. Due to (or as a consequence of):<br><b>chronic obstructive pulmonary disease</b>  | 20 years                                     |  |  |
| b. Due to (or as a consequence of):  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |
| d. _____   |  |  |  |

|   |  |   |
|---|--|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br/>9 <input type="checkbox"/> Unknown</b> | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b> | 23d. Date of delivery<br>Month Day Year |
|---|--|---|

|  |   |
|--|---|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |
|--|---|

|  |  |  |
|--|--|--|
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |
|--|--|--|

|  |  |                          |   |  |
|--|--|--------------------------|---|--|
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide<br/>4 <input type="checkbox"/> Homicide</b> | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred  |
|  |  |                          |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |                     |                                     |
|--|---------------------|-------------------------------------|
| 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>only one<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> | 29c. License number | 29d. Date signed (Month, Day, Year) |
|--|---------------------|-------------------------------------|

|   |               |                    |
|---|---------------|--------------------|
| 29b. Signature and title of certifier<br> | <b>D68240</b> | <b>May 14 2012</b> |
|---|---------------|--------------------|

|  |                           |
|--|---------------------------|
| 31. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 32. Registrar's Signature |
| <b>Vadim Korlchov 301 Hospital Dr, Glen Burnie, MD 21061</b>                         |                           |

31. Date filed (Month, Day, Year)

**MAY 15 2012**

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15435

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |  |   |   |   |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|---|---|--|---|--|--|--|--|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Beatrice Woodson</b>   |  |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>05/03/2012</b>     |  | 3. Time of Death<br>7:40 a.m.                          |  |  |  |   |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>9004 Riggs Road Apt. 107</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Adelphi</b>  |   |  | 4c. County of Death<br><b>Prince Georges</b>                |  |  |  |  |  |   |  |
| Funeral<br>Director  |  | 5. Social Security Number<br><b>579-52-0965</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b><br>Yrs.   | If Under 1 Year<br>Months<br><input type="checkbox"/> Days<br>Hours<br><input type="checkbox"/> Min.  | If Under 24 Hrs.<br>Hours<br><input type="checkbox"/> Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/11/1942</b> | 9. Birthplace (State or Foreign Country)<br><b>D. C.</b>                                       |  |  |  |  |   |  |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Prince Georges</b>  |   | 10c. City, Town or Location<br><b>Adelphi</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |   |  |
|  |  | 10e. Street and Number<br><b>9004 Riggs Road #107</b>  |  |   | 10f. Zip Code<br><b>20783</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |  |  |  |  |   |  |
|  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b><br>Specify:                     |  |  |  |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b>  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Paralegal Specialist</b> |   |  | 16b. Kind of Business/Industry<br><b>Private Firm</b>       |  |  |  |  |  |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Harrison Woodson</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maxine Smith</b>  |   |  |   |  |  |  |  |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeffrey A. Woodson (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>717 Tola Ct. Hyattsville, Md. 20785</b>   |   |   |  |   |  |  |  |  |  |   |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Lincoln Memorial</b>  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial</b>   |   |  | Date<br><b>05/12/2012</b>                                   | 20c. Location - City or Town, State<br><b>Suitland, Md.</b>                                    |  |  |  |  |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>cc0278</b>   |  |   | 22. Name and Address of Facility<br><b>Latney's Funeral Home 3831 Georgia Ave., NW Washington, DC 20001</b>                                 |   |  |   |  |  |  |  |  |   |  |
| Physician<br>Medical<br>Examiner                                   |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer Metastatic to Brain</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. _____  |  |   |   |   |  |   |  |  |  |  |  |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |  |  |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Tobacco Use</b>   |  |   |   |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |  |  |   |   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA   |   |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |   |  |  |  |  |  |   |  |
|  |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred                           |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |   |  |  |  |  |  |   |  |
|  |  | 29b. Signature and title of certifier<br><b>Lisa Lee</b>   |  |   |   |   | 29c. License number<br><b>MD32535</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/2012</b> |  |  |  |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lisa Lee, MD 2100 Pa. Ave., NW Washington, DC 20037</b>   |  |   |   |   |  |   |  |  |  |  |  |   |  |
| State<br>Registrar   |  | 31. Date filed (Month Day Year)<br><b>MAY 15 2012</b>  |  |   |   |   | 32. Registrar's Signature<br><b>Lisa Lee</b>   |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2012 15436

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marjorie Marie Wright</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> , Year <b>2012</b>  |  | 3. Time of Death<br><b>8:45p</b> M   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Adelphi House</b>   |  | 4b. City, Town, or Location of Death<br><b>Adelphi</b>   |  | 4c. County of Death<br><b>PG</b>   |  |
| 5. Social Security Number<br><b>577-48-3133</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days Hours Min.  |  |
|  |  |  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>12-25-1934</b>  | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b>                                    |
| Funeral Director<br>To Be Completed by Funeral Director  |  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>PG</b> 10c. City, Town or Location <b>Hyattsville</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | 10e. Street and Number<br><b>5009 40th Pl.</b>   |  | 10f. Zip Code<br><b>20781</b>  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Guidance Counselor</b>  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Marshall Jackson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary McCollough</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maxine Jackson/Sister</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5009 40th Pl. Hyattsville, MD 20781</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial Cem</b>  |  | Date<br><b>5-18-2012</b>   | 20c. Location - City or Town, State<br><b>Suitland, MD</b>                                     |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Ronald Taylor II Funeral Home<br/>10583 Middleport Ln. White Plains, MD 20695</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | Approximate Interval Between Onset and Death   |  |  |  |
| a. Due to (or as a consequence of):<br><b>Metastatic Breast Cancer</b>   |  |  |  |  |  |
| b. Due to (or as a consequence of):  |  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                              |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>ASSISTED LIVING</b> |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>20 Mayo Rd Edgewater, MD 21037</b>  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>J 40209</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/12</b>  |  |
| 29b. Signature and title of certifier<br>  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jacinth Brooks MD; 20 Mayo Rd Edgewater, MD 21037</b>   |  | 32. Registrar's Signature<br>  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 33. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15437

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|  |  |  |  |  |   |  |  |   |  |                               |  |
|--|--|--|--|--|---|--|--|---|--|-------------------------------|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Tonisha R. Ward</b>   |  |  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>May 7, 2012</b>    |  | 3. Time of Death<br>9:55 a.m. |  |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Prince Georges Hospital</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  |  | 4c. County of Death<br><b>PG</b>                            |  |                               |  |
| Funeral Director   |  | 5. Social Security Number<br><b>577-23-5784</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>04-23-1992</b>  | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b> |  |                               |  |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>DC</b>  | 10b. County  | 10c. City, Town or Location<br><b>Washington</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |                               |  |
|  |  | 10e. Street and Number<br><b>218 Division Ave. NE</b>  |  |  | 10f. Zip Code<br><b>20019</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |                               |  |
|  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |                               |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b>   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>Student</b>   | 16b. Kind of Business/Industry<br><b>Private</b>   |   |  |  |   |  |                               |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>William Montgomery</b>   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Antionette Ward</b>  |  |   |  |  |   |  |                               |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Antionette Ward/Mother</b>  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>218 Division Ave. NE Washington DC 20019</b>   |  |   |  |  |   |  |                               |  |
| Physician/<br>Medical<br>Examiner                                  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Heritage Memorial Pk.</b>   | Date<br><b>5-18-12</b>   | 20c. Location - City or Town, State<br><b>Waldorf, MD</b>   |  |  |   |  |                               |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br>  | 22. Name and Address of Facility<br><b>Ronald Taylor Funeral Home<br/>10583 Middleport Ln. White Plains, MD 20695</b>  |  |   |  |  |   |  |                               |  |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death, or do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  | Approximate Interval Between Onset and Death  |  |  |   |  |                               |  |
|  |  | a.<br>   |  |  |   |  |  |   |  |                               |  |
|  |  | b.<br>   |  |  |   |  |  |   |  |                               |  |
|  |  | c.<br>   |  |  |   |  |  |   |  |                               |  |
|  |  | d.   |  |  |   |  |  |   |  |                               |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   | 23c. If yes, outcome of pregnancy<br><input checked="" type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) |  |   | 23d. Date of delivery<br>Month Day Year  |  |   |  |                               |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |                               |  |
|  |  |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | Hospital:  | 26. Place of Death (Check only one)<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 28d. Describe how injury occurred  |   |  |                               |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |   |  |                               |  |
|  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |                               |  |
|  |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |  |                               |  |
|  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>030318</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/7/12</b>   |   |  |                               |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Latavious 300 Hospital Dr Cheverly MD 20785</b>   |  |  |   |  |  |   |  |                               |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |                               |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15438

1- For  
State  
Registrar

|  |  |  |  |   |                              |                           |  |   |  |  |
|--|--|--|--|---|------------------------------|---------------------------|--|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>ROSETTA YANCY</b>   |  |  |   |                              |                           | 2. Date of Death<br>Month <b>May</b> , Day <b>11</b> , Year <b>2012</b>  | 3. Time of Death<br><b>5:35PM</b>                           |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>5737 Race Road</b>  |  |  | 4b. City, Town, or Location of Death<br><b>ElKridge</b>   |                              |                           | 4c. County of Death<br><b>Howard</b>   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-18-2788</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |                              | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>2-28-1925</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent<br><b>MD Howard</b>  |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Howard</b> |                           | 10c. City, Town or Location<br><b>ElKridge</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>5737 Race Road</b>  |  |  | 11f. Zip Code<br><b>21075</b>   |                              |                           | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |                              |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>Black</b> |   |  |  |
|  | 14. Race - American Indian, Black, White, etc.   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |                              |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |   |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b> |
|  | 17. Father's Name (First, Middle, Last)<br><b>Francis Griffin</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Henson</b>   |                              |                           |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Roger Mundell (Nephew)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5737 Race Road, ElKridge, MD 21075</b>        |                              |                           |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Baltimore National</b>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>5-18-12</b>  |                              |                           | Date   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b> |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>   |  |  | 22. Name and Address of Facility<br><b>Greene funeral Services<br/>5151 Baltimore Nat'l Pkce (21229)</b>  |                              |                           |  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CORONARY ARTERY DISEASE</b><br>Approximate Interval Between Onset and Death<br><b>3 years.</b>  |  |  |   |                              |                           |  |   |  |  |
|  | 23b. If female:<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |  |   |                              |                           |  |   |  |  |
|  | 23d. Date of delivery<br>Month Day Year  |  |  |   |                              |                           |  |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADVANCED ALZHEIMER'S DEMENTIA<br/>ESSENTIAL HYPERTENSION<br/>BILATERAL SUBDURAL HEMATOMAS</b>   |  |  |   |                              |                           |  |   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |   |                              |                           |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                              |                           |  |   |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |                              |                           |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                              |                           |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |                              |                           |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |  |   |                              |                           |  |   |  |  |
|  | 28a. Date of injury (Month, Day, Year) <b>28b. Time of injury M</b> <b>28c. Injury at work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |                              |                           |  |   |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |                              |                           |  |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                              |                           |  |   |  |  |
|  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                              |                           |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>Komal K. Dang MD</b>   |  |  |   |                              |                           |  |   |  |  |
|  | 29c. License number<br><b>D0018362</b>   |  |  |   |                              |                           |  |   |  |  |
|  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>  |  |  |   |                              |                           |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Komal K. Dang MD. 3455 Wilkens Ave, Ste 410; Baltimore, MD 21229</b>  |  |  |   |                              |                           |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  |  | 32. Registrar's Signature<br><b>Komal K. Dang</b>   |                              |                           |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760  
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15439

**1-** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)   |  |   |  |   |  | 2. Date of Death   |  | 3. Time of Death   |  |   |  |
|  |  | Joseph Yankovich   |  |   |  |   |  | Month <b>May</b> Day <b>9</b> , Year <b>2012</b>   |  | 8:00 PM  |  |   |  |
|  |  | 4a. Facility Name (if not institution, give street and number)   |  |   |  |   |  | 4b. City, Town, or Location of Death   |  | 4c. County of Death  |  |   |  |
|  |  | Kline House  |  |   |  |   |  | Mt. Airy   |  | Frederick  |  |   |  |
| <b>Funeral<br/>Director</b>                |  | 5. Social Security Number<br><b>561-36-5631</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 15 1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |
| <b>To Be Completed by Funeral Director</b> |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|  |  | 10e. Street and Number<br><b>2395 Bear Den Road</b>  |  |   |  | 10f. Zip Code<br><b>21701</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |   |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1943-45</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b> 2  |  | Legal Analyst   |  | 16b. Kind of Business/Industry<br><b>New York State Senate</b>   |  |  |  |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Jozef Yankovich</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Rupert</b>   |  |   |  |  |  |  |  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn Yankovich / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2395 Bear Den Rd. Frederick, MD 21701</b>   |  |   |  |  |  |  |  |   |  |
|  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Final Journey Crematory</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MO1251</b>   |  | Date<br><b>5/11/2012</b>  |  | 20c. Location - City or Town, State<br><b>Woodbine, Maryland</b>   |  |  |  |   |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Bernard L. Hecht</b>   |  | 22. Name and Address of Facility<br><b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>   |  |   |  |  |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b> |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
|  |  | Immediate Cause (Final disease or condition resulting in death)  |  |   |  |   |  |  |  |  |  |   |  |
|  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last   |  |   |  |   |  |  |  |  |  |   |  |
|  |  | <p>a. <b>Asystoles</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Hypoxia</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Respiratory Arrest</b><br/>Due to (or as a consequence of):</p> <p>d. <b>Encephalopathy</b></p>   |  |   |  |   |  |  |  | minutes  |  |   |  |
|  |  |  |  |   |  |   |  |  |  | minutes  |  |   |  |
|  |  |  |  |   |  |   |  |  |  | hours  |  |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Small Cell Carcinoma of Prostate</b>  |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>  |  |  |  |  |  |   |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                     |  | 28d. Describe how injury occurred  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|  |  | 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|  |  | 29b. Signature and title of certifier<br><b>Kathy</b>  |  | 29c. License number<br><b>D67442</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>  |  |  |  |  |  |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Yun W. Oh 46B Thomas Johnson Dr. Frederick, MD 21702</b>  |  |   |  |   |  |  |  |  |  |   |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br><b>Susan J. Park</b>   |  |   |  |  |  |  |  |   |  |

**Baltimore, Maryland 21215-0036**

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**Medical Certificate: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15440

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

RUTH ZAHN- GROLL

2. Date of Death

Month Day

Year

3. Time of Death

2:50 P M

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

STELLA MARIS

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTO.

Funeral  
Director

5. Social Security Number

214-20-2965

Usual Residence of Decedent

6. Sex

1  M 2  F

7. Age (in yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

5-22-1922

9. Time of Death

GERMANY

To Be Completed by Funeral Director

10a. State

MD.

10b. County

BALTO.

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

2300 DULANEY VALLEY ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No  
Specify:

14. Race - American Indian, Black, White, etc.  
Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

MEDICAL SECRETARY

16b. Kind of Business/Industry

DOCTOR OFFICE

17. Father's Name (First, Middle, Last)

ROBERT W. JENTZSCH

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE H. FRISCH

19a. Informant's Name/Relationship (Type, Print)

ERIKA WILMOTH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DTR. 2824 ERIE AVENUE PARKVILLE, MD. 21234

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ATLANTIC CREMATORY

Date

5-11, 2012

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

6415 BELAIR ROAD BALTO. MD. 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**CORONARY ARTERY DISEASE**

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 3  Suicide 6  Could not be determined  
4  Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one  
3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

R043580

29d. Date signed (Month, Day, Year)

05-09-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSTINE..PREIS, CRNP

2300 DULANEY VALLEY ROAD

TIMONIUM MD 21093

31. Date filed (Month, Day, Year)

MAY 15 2012

32. Registrar's Signature

2:50 P.M.

MAY 8, 2012  
Baltimore, Maryland 21215-0036

GROLL  
RUTH

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 30 per dvr g927 5-15-12 vt  
 State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No.

2012 1544

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

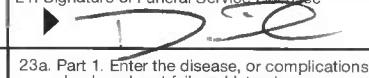
Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

|  |  |   |  |   |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month MAY Day 12 Year 2012  |  | 3. Time of Death<br>9:59 AM   |
| NORMAN I ZIPPER  |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)<br>3608 GARDENVIEW COURT  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>BALTIMORE  |
| 5. Social Security Number<br>213-16-6004   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs.  | 8. Date of Birth<br>(Month, Day, Year)<br>07/28/1922  |
| 9. Birthplace (State or Foreign Country)<br>MD   |  | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 10a. State<br>MD   |  | 10b. County<br>BALTIMORE  | 10c. City, Town or Location<br>BALTIMORE   |   |
| 10e. Street and Number<br>3608 GARDENVIEW COURT  |  | 10f. Zip Code<br>21208  |  | 10g. Citizen of What Country?<br>USA  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>WHITE |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |  |   |
| 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>OPTOMETRIST  |  | 16b. Kind of Business Industry<br>MEDICAL   |  |   |
| 17. Father's Name (First, Middle, Last)<br>GERSHON ZIPPER  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ANNIE SCHWARTZ   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>MARGOT ZIPPER/WIFE   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3608 GARDENVIEW COURT, BALTIMORE, MD 21208   |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ARLINGTON CHIZUK AMUNO CEMETERY   | Date<br>05/14/2012   | 20c. Location - City or Town, State<br>BALTIMORE, MD  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>SOL LEVINSON & BROS., INC.<br>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |   |
| a. Due to (or as a consequence of):<br><i>Chronic Renal Failure</i><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |   |
| Approximate Interval Between Onset and Death<br>5 yrs  |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><i>High blood pressure</i>   |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  |   |
| 29c. License number<br>D33974  |  | 29d. Date signed (Month, Day, Year)<br>5/13/12  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Aaron Goldberg 2825 Smith Ave. #207 Baltimore, Md. 21209   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |  | 32. Registrar's Signature<br>  |  |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15442

1 - For State Registrar

|   |  |  |   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Edmund Burke</b>   |  |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 24, 2012</b>  |  | 3. Time of Death<br>11:07 p <sup>M</sup> |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  |   | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>029-22-1927</b>  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b>  | If Under 1 Year<br>Months<br><b>0</b>  | If Under 24 Hrs.<br>Days<br><b>0</b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 15 1931</b> | 9. Birthplace (State or Foreign Country)<br><b>MA</b>  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  |   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Rockville</b>  |   |  | 10d. Inside City Limits<br><b>1 □ Yes 2 X No</b> |  |  |
|   | 10e. Street and Number<br><b>5529 Marlin Street</b>  |  |   | 10f. Zip Code<br><b>20853</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|   | 11. Marital Status<br><b>1 □ Never Married 2 X Married</b><br>3 □ Widowed 4 □ Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 X Yes 4 □ No</b><br>If Yes, Give Year or Dates<br><b>Korean Conflict</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No</b> Specify:<br><b>White</b> | 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  |   |  |  |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>   | 16b. Kind of Business Industry<br><b>4 Computers &amp; Technology Federal Government</b> |   |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Francis J. Burke, Sr.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose M. Doherty</b>  |  |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Coral L. Burke/Wife</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5529 Marlin Street, Rockville, MD 20853</b>                                    |  |   |  |  |  |  |
| Physician/<br>Medical<br>Examiner             | 20a. Method of Disposition<br><b>1 X Burial 2 □ Cremation 3 □ Removal from State</b><br>4 □ Donation 5 □ Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery or other place)<br><b>St. Mary's Cemetery - Barnesville</b>  | Date<br><b>May 1, 2012</b>   | 20c. Location - City or Town, State<br><b>Barnesville, MD</b> |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>✓ Andrew J. Cole</b>   |  |   | 22. Name and Address of Facility<br><b>Cole Funeral Services, P.A.<br/>4110 Aspen Hill Road, Ste. 100, Rockville, MD</b>   |  |   |  |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   | Approximate Interval Between Onset and Death<br><b>Hours</b>   |  |   |  |  |  |  |
|   | a. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br><b>BACTEREMIA</b>  |  |   |  |  |   |  |  |  |  |
|   | b. <b>URINARY TRACT INFECTION</b><br>Due to (or as a consequence of):  |  |   | <b>DAYS</b>  |  |   |  |  |  |  |
|   | c. <b>URINARY TRACT INFECTION</b><br>Due to (or as a consequence of):  |  |   |  |  |   |  |  |  |  |
|   | d. <b>URINARY TRACT INFECTION</b><br>Due to (or as a consequence of):  |  |   |  |  |   |  |  |  |  |
|   | IF FEMALE:   |  |   | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy</b><br><b>4 □ Pregnant at time of death 5 □ Other (specify)</b><br><b>9 □ Unknown</b> |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b>   |  |   | 24a. Was an autopsy performed?<br><b>1 □ Yes 2 X No</b>  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 □ No</b> |  |  |  |
|   | 25. Was case referred to medical examiner?<br><b>1 □ Yes 2 X No</b>  |  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 □ ER/Outpatient 3 □ DOA</b><br>Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>                |  |   |  |  |  |  |
|   | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation</b><br><b>2 □ Accident 6 □ Could not be determined</b><br><b>3 □ Suicide 4 □ Homicide</b>  |  |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>                 | 28d. Describe how injury occurred  |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                         |  |  |  |
|   | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>(Check only one)</b><br><b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   | 29c. License number<br><b>D0069451</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25 2012</b>  |  |  |  |
|   | 29b. Signature and title of certifier<br><b>✓ Huy N. NGUYEN, MD</b>  |  |   |  |  |   |  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Huy N. NGUYEN, MD 9901 MEDICAL CENTER DR. ROCKVILLE, MD</b>   |  |   |  |  |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 02 2012</b>  |  |   | 32. Registrar's Signature<br><b>Anna S. Parks</b>  |  |   |  |  |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Burke, Paul E. DOB 11/15/31 Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15443

|  |  |   |  |  |  |   |   |  |  |  |
|--|--|---|--|--|--|---|---|--|--|--|
| 1- For State Registrar   |  | Decedent's Name (First, Middle, Last)<br><b>NANCY BADERTSCHER</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>4 26 12</b>  |   | 3. Time of Death<br>2:12 P M   |  |  |
| Physician/ Medical Examiner  |  | 4a. Facility Name (if not institution, give street and number)<br><b>MANDRIN INPATIENT CARE CENTER</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>HARWOOD</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |  |
| Funeral Director   |  | 5. Social Security Number<br><b>026-38-8945</b>   |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>48 Yrs.</b> | If Under 1 Year<br>Months<br><b> </b>   | If Under 24 Hrs.<br>Days<br><b> </b>                  | 8. Date of Birth<br>(Month, Day, Year)<br><b>12/3/1963</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>FALL RIVER MASSACHUSETTS</b>              |  |
| To Be Completed by Funeral Director                                |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>   |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |  |
|  |  | 10e. Street and Number<br><b>1664 WOOD TREE COURT EAST</b>  |  |  |  | 10f. Zip Code<br><b>21409</b>   | 10g. Citizen of What Country?<br><b>UNITED STATES</b> |  |  |  |
|  |  | 11. Marital Status<br><b>1 Never Married 2 Married</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:<br><b> </b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |  |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 5+ MUSIC TEACHER</b>        |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>  |   |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>FRANKLIN GRAY</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORENCE BELL</b>   |   |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ERIC A. BADERTSCHER/HUSBAND</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1664 WOOD TREE COURT EAST ANNAPOLIS, MD 21409</b>              |  | Date<br><b>5/2/2012</b>   |   | 20c. Location - City or Town, State<br><b>ANNAPOLIS, MD</b>                                      |  |  |
|  |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State</b><br>4 Donation 5 Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BESTGATE MEMORIAL PARK</b>  |  | Date<br><b>5/2/2012</b>   |   | 20c. Location - City or Town, State<br><b>ANNAPOLIS, MD</b>                                      |  |  |
|  |  | 21. Signature of Funeral Service Licensee<br><b>Thomas K. Helfenbein</b>  |  | 22. Name and Address of Facility<br><b>LASTING TRIBUTES BY FELLOWS HELFENBEIN &amp; NEWMAN CREMATION &amp; FUNERAL CARE 814 BESTGATE ROAD ANNAPOLIS, MD 21401</b>  |  |   |   |  |  |  |
| Physician/ Medical Examiner  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b>  |  |  |  |   |   | Approximate Interval Between Inset and Death<br><b>MONTHS</b>                                    |  |  |
|  |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No</b><br>9 Unknown   |  | 23c. If yes, outcome of pregnancy<br><b>1 Live Birth 2 Fetal death 3 Ectopic pregnancy</b><br>4 Pregnant at time of death 5 Other (Specify)<br>9 Unknown           |  | 23d. Date of delivery<br>Month Day Year   |   |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |   |  |  |  |
|  |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DDA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) MANDRIN HOUSE</b> |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |  |
|  |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> 5 Pending Investigation 6 Could not be determined   |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br><b>1 Yes 2 No</b>   | 28d. Describe how injury occurred<br><b> </b>         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b> </b> |  |
|  |  | 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. Signature and title of certifier<br><b>G-L-Taylor NP</b>  |  | 29c. License number<br><b>R118703</b>   | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b> |  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>GENEVIEVE L-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, MD 21401</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |  | 32. Registrar's Signature<br><b>Connie S. Parker</b>  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EO  
5

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15444

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. Decedent's Name (First, Middle, Last)   |  | JOHN MANNING BLAKELEY  |   | 2. Date of Death<br>Month April Day 24 Year 2012  | 3. Time of Death<br>0625 AM                           |
| 4a. Facility Name (if not institution, give street and number)   |  | Peninsula Regional Medical Center  |   | 4b. City, Town, or Location of Death<br>SALISBURY   |   |
| 4c. County of Death<br>Hicomics  |  |  |   |   |   |
| 5. Social Security Number<br>221-18-3788   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>88 Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br>11-20-1923  | 9. Birthplace (State or Foreign Country)<br>DELAWARE  |
| 8. Date of Birth<br>(Month, Day, Year)<br>11-20-1923   |  | If Under 1 Year<br>Months      Days      Hours      Min.   |   | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10a. State<br>DE   |  | 10b. County<br>SUSSEX  |   | 10c. City, Town or Location<br>GEORGETOWN   |   |
| 10e. Street and Number<br>421 W. MARKET ST.  |  | 10f. Zip Code<br>19947   |   | 10g. Citizen of What Country?<br>USA  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>WHITE |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) MECHANIC   |   | 16b. Kind of Business/Industry<br>AUTOMOTIVE  |   |
| 17. Father's Name (First, Middle, Last)<br>RALPH BLAKELEY  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ALLENE WYATT  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>PATRICIA B. CALHOUN  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8028 DUPONT BLVD., MILFORD, DE 19963  |   |   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ST. PAUL'S CEM.  |   | Date<br>4-30-2012   | 20c. Location - City or Town, State<br>GEORGETOWN, DE |
| 21. Signature of Funeral Service Licensee<br>George M. Shott   |  | 22. Name and Address of Facility<br>SHORT FUNERAL SERVICES<br>416 FEDERAL ST., MILTON, DE 19968  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,<br>shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br>Congestive Heart Failure  |   | Approximate Interval Between Onset and Death<br>months  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br>Acute- and Chronic Renal Failure  |   | years   |   |
| {  |  | 23d. Due to (or as a consequence of):<br>ASCVD   |   | years   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23e. Date of delivery<br>Month Day Year  |   |   |   |
| 23f. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23g. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23h. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 23i. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred                     |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>020912  |   | 29d. Date signed (Month, Day, Year)<br>5/3/12   |   |
| 29b. Signature and title of certifier<br>Dennis Chodnick, MD   |  | 29c. License number<br>020912  |   | 29d. Date signed (Month, Day, Year)<br>5/3/12   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis Chodnick, MD 100 E. Shore Dr. SALISBURY MD 21801  |  | 31. Date filed (Month, Day, Year)<br>MAY 15 2012   |   | 32. Registrar's Signature<br>Dennis P. Parker   |   |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 15445

Reg. No.

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |
|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>NATALIE FRANCES CRANE</b>   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>30</b> Year <b>2012</b>   | 3. Time of Death<br>16:40 M  |
| 4a. Facility Name (if not institution, give street and number)<br><b>611 BUSIC CHURCH ROAD</b>   |  | 4b. City, Town, or Location of Death<br><b>SUDLERSVILLE</b>   |  |
| 4c. County of Death<br><b>QUEEN ANNE'S</b>   |  | 3. Time of Death<br>16:40 M   |  |
| 5. Social Security Number<br><b>152-18-7668</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. <b>85</b>   |
| 8. Usual Residence of Decedent<br><b>MD QUEEN ANNE'S</b>   |  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  |
|  |  | Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>12/13/1926</b>  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>QUEEN ANNE'S</b>  | 10c. City, Town or Location<br><b>SUDLERSVILLE</b>   |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| 10e. Street and Number<br><b>611 BUSIC CHURCH ROAD</b>   |  | 10f. Zip Code<br><b>21168</b>   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>2</b>  | 16b. Kind of Business/Industry<br><b>ADMINISTRATOR</b> <b>HEALTH CARE</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>JACOB DEWEY MEURER</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VESTA NATALIE MARKEL</b>   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KATHERINE GOYETTE / NIECE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4285 CARPENTER BRIDGE ROAD, FELTON, DE 19943</b>  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER</b>  | Date<br><b>05/02/2012</b>  |
| 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A.</b><br><b>408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617</b>   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |
| <p>a. <b>HEART ATTACK</b><br/>Due to (or as a consequence of):</p> <p>b. <b>CORONARY HEART DISEASE</b><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERLIPIDEMIA</b><br><b>HTN, PRIOR CVA</b>   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   |
|  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>C1-0002688 (DE)</b>   |  |
| 29b. Signature and title of certifier<br>   |  | 29d. Date signed (Month, Day, Year)<br><b>05/01/2012</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL SWEENEY</b> <b>725 S. QUEEN ST., DOVER, DE 19904</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY -2 2012</b>  |  | 32. Registrar's Signature<br>  |  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2012 15446

Reg. No.

|  |  |   |   |  |   |  |   |   |  |
|--|--|---|---|--|---|--|---|---|--|
| 1 - For State Registrar  |  | 1. Decedent's Name (First, Middle, Last)<br><i>Barbara Connell</i>  |   |  |   | 2. Date of Death<br>Month <u>04</u> Day <u>27</u> Year <u>2012</u>   |   | 3. Time of Death<br><u>4:58 PM</u>                          |  |
| Physician/<br>Medical<br>Examiner                                  |  | 4a. Facility Name (if not institution, give street and number)<br><b>Heritage Harbour Health Center</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>                  |  |
| Funeral<br>Director  |  | 5. Social Security Number<br><b>212-28-9743</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b>   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>1/7/1932</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
| To Be Completed by Funeral Director                                |  | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b>   |   |  |   | 10c. City, Town or Location<br><b>Annapolis</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | 10e. Street and Number<br><b>500 Sixth Street Apt 1</b>   |   |  |   | 10f. Zip Code<br><b>21403</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                 |  |
|  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>Elementary/Secondary (0-12) 12</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> | 14. Race - American Indian, Black, White, etc.  |  |   |   |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>College (1-4 or 5+) Payroll Clerk</b>   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Payroll Clerk</b>   | 16b. Kind of Business/Industry<br><b>State of Maryland</b>   |   |  |   |   |  |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>William Connell</b>   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Russell</b>   |  |   |  |   |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eleanor Noe - Sister</b>   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>130 Hearne Road Apt 1007, Annapolis, MD 21401</b>   |  |   |  |   |   |  |
| Physician/<br>Medical<br>Examiner                                  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Baltimore Crematory</b>   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Crematory</b>  | Date<br><b>5/1/2012</b>  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                 |  |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><i>Myelin T. Robert</i>  | 22. Name and Address of Facility John M. Taylor Funeral Home<br><b>147 Duke of Gloucester St, Annapolis, MD 21401</b>   |  |   |  |   |   |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular Disease</b>  |   |  |   | Approximate Interval Between Onset and Death   |   |   |  |
|  |  | a. Due to (or as a consequence of):<br><b>Hypertension</b>  |   |  |   |  |   |   |  |
|  |  | b. Due to (or as a consequence of):<br><b>Stroke (check consequences)</b>   |   |  |   |  |   |   |  |
|  |  | c. Due to (or as a consequence of):   |   |  |   |  |   |   |  |
|  |  | d. _____  |   |  |   |  |   |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month      Day      Year  |   |  |   |   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |  |
|  |  |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |   |   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
|  |  | 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |   |  |
|  |  | 29b. Signature and title of certifier<br><i>Syed MAHBOOB</i>  | 29c. License number<br><b>D0070693</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>04-27-2012</b>  |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SYED MAHBOOB</b>   |   |  |   | 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b>  |   |   | 32. Registrar's Signature<br><i>Leanne B. Parker</i>   |

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

E5  
3

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar Amend Items 25, 27, 28a-f per me, g927, 05/11/2012dhb State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 15447

|   |   |  |   |  |   |   |  |                                    |
|---|---|--|---|--|---|---|--|------------------------------------|
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Isabelle Gladys Cowan</b>  |  |   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 27 2012</b>                                     | 3. Time of Death<br><b>3:53 PM</b> |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Lutheran Village</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |   |   | 4c. County of Death<br><b>Carroll</b>  |                                    |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>220-18-0500</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>91 Yrs.</b>  | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>07/27/1920</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |                                    |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Westminster</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                    |
|   | 10e. Street and Number<br><b>846 Hughes Shop Rd.</b>  |  |   | 10f. Zip Code<br><b>21158</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |                                    |
| <b>Physician/<br/>Medical<br/>Examiner</b>  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |                                    |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>8</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                             | 16b. Kind of Business/Industry<br><b>Homemaker</b>  |  |   |   |  |                                    |
| 17. Father's Name (First, Middle, Last)<br><b>Carl Allen Hubbard</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ellen Sullivan</b>  |   |   |  |                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gregory Cowan-son</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>846 Hughes Shop Rd. Westminster, MD 21158</b>           |  |   |   |  |                                    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>► Thomas D. Fletcher III</b>  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Finksburg Cem.</b>   | Date<br><b>5/2/2012</b>  | 20c. Location - City or Town, State<br><b>Finksburg</b>                                     |   |  |                                    |
| 21. Signature of Funeral Service License<br><b>► Thomas D. Fletcher III</b>   |   |  | 22. Name and Address of Facility<br><b>Fletcher Funeral Home, P.A.<br/>254 E. Main St. Westminster, MD 21157</b>  |  |   |   |  |                                    |
| <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of):<br/><b>Respiratory Failure</b></p> <p>b. Due to (or as a consequence of):<br/><b>Left Hip fracture</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p><i>► Thomas D. Fletcher III, MD<br/>CERTIFICATION APPROVED BY MEDICAL EXAMINER</i></p> |   |  |   |  |   |   |  |                                    |
| IF FEMALE:  |   | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown |   |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |                                    |
| <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>COPD, HTN, AFib</b></p>   |   |  |   |  |   |   |  |                                    |
| <p>23e. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>  |   |  |   |  |   |   |  |                                    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |   |  |   |   |  |                                    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> COA   |   | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><b>Fall</b> |   |   |  |                                    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)<br><b>04/22/2012</b>   |   | 28b. Time of injury<br><b>2:30 PM</b>  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Fall</b>  |  |                                    |
| <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br/><b>Nursing Home</b></p>   |   |  |   |  |   |   |  |                                    |
| <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br/><b>300 St. Luke Circle Westminster, MD</b></p>  |   |  |   |  |   |   |  |                                    |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |  |   |   |  |                                    |
| 29b. Signature and title of certifier<br><b>► Ofcensurey</b>  |   |  |   | 29c. License number<br><b>D0051705</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 2012</b>  |  |                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Maycen Pansuriya MD. 349 Malcolm Dr. Westminster MD 21157</b>  |   |  |   |  |   |   |  |                                    |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   | 32. Registrar's Signature<br><b>Leanne J. Spars</b>  |   |  |   |   |  |                                    |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15448

1- For State  
Registrar**Physician/  
Medical Examiner**

|  |                  |     |      |          |                  |
|--|------------------|-----|------|----------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death |     |      |          | 3. Time of Death |
| <b>Dorian Dale Dutton</b>                | Month            | Day | Year | 1358 hrs |                  |
| April 22, 2012                           |                  |     |      |          |                  |

**Funeral  
Director**

|  |   |                                |                 |                              |  |              |             |                 |           |
|--|---|--------------------------------|-----------------|------------------------------|--|--------------|-------------|-----------------|-----------|
| 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death  |                                |                 | 4c. County of Death          |  |              |             |                 |           |
| <b>Penninsula Regional Medical Center</b>                      | <b>Saulsbury</b>  |                                |                 | <b>Wicomico</b>              |  |              |             |                 |           |
| 5. Social Security Number                                      | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Foreign Country) |              |             |                 |           |
| <b>219-62-8642</b>   | <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | <b>53</b>                      | <b>Yrs.</b>     | <b>Months</b>                | <b>Days</b>                              | <b>Hours</b> | <b>Min.</b> | <b>6-5-1958</b> | <b>MD</b> |

**Baltimore, MD 21215-0036**  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

|                               |                 |                             |  |  |                               |
|-------------------------------|-----------------|-----------------------------|--|--|-------------------------------|
| Usual Residence of Decedent   |                 | 10d. Inside City Limits     |  |  |                               |
| 10a. State                    | 10b. County     | 10c. City, Town or Location |  |  |                               |
| <b>MD</b>                     | <b>Wicomico</b> | <b>Fruitland</b>            |  |  |                               |
| 10e. Street and Number        |                 | 10f. Zip Code               |  |  | 10g. Citizen of What Country? |
| <b>405 N. Division Street</b> |                 | <b>21826</b>                |  |  | <b>USA</b>                    |

|   |  |   |  |
|---|--|---|--|
| 11. Marital Status  | 12. Was Decedent Ever in U.S. Armed Forces?                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b> | <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> | <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:</b>                     | <b>Black</b>                                   |

|   |   |                                |
|---|---|--------------------------------|
| 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| <b>Elementary/Secondary (0-12) 9</b>                            | <b>College (1-4 or 5+) Carpet Layer</b>   | <b>Self-employed</b>           |

|  |   |
|--|---|
| 17. Father's Name (First, Middle, Last)          | 18. Mother's Name (First, Middle, Maiden Surname)   |
| <b>Edward J. Dutton</b>                          | <b>Edith M. Wright</b>  |
| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| <b>Shanda D. Murray/Daughter</b>                 | <b>133 Wesley Ave, Baltimore, MD 21228</b>  |

|  |  |                  |                                     |
|--|--|------------------|-------------------------------------|
| 20a. Method of Disposition   | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date             | 20c. Location - City or Town, State |
| <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:</b> | <b>Flower Hill Cem</b>   | <b>4-28-2012</b> | <b>Eden, MD</b>                     |

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility   |
| <b>Priscilla Round</b>                    | <b>917 W. Isabella St.<br/>Bennie Smith Funeral Home Salisbury, MD 21801</b> |

**Physician  
Medical Examiner**

|   |  |
|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
| a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):   |  |

|  |  |
|--|--|
| b. _____<br>Due to (or as a consequence of): |  |
| c. _____<br>Due to (or as a consequence of): |  |
| d. _____                                     |  |

|   |  |
|---|--|
| <b><input checked="" type="checkbox"/> UNPENDED</b> | <b><input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g927 5-16-12 sm</b> |
|---|--|

**Division of Vital Records, P.O. Box 68760.**  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|  |  |   |
|--|--|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
| <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b> |  |   |

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| <b>Diabetes Mellitus</b>   |  |

|  |  |                                     |
|--|--|-------------------------------------|
| 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: | 26. Place of Death (Check only one) |
|--|--|-------------------------------------|

|  |  |                     |  |  |
|--|--|---------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide      4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |  |                     |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|  |   |  |  |
|--|---|--|--|
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>April 23, 2012</b> |
|--|---|--|--|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |                               |
|---|-------------------------------|
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b> | 32. Registrar's Signature<br> |
|---|-------------------------------|

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15449

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

*Anne Marie Dailey*

2. Date of Death

Month APRIL Day 29 Year 2012

3. Time of Death  
2:30 PM

4a. Facility Name (if not institution, give street and number)

501 BAYSIDE DRIVE

4b. City, Town, or Location of Death

STEVENSVILLE

4c. County of Death

QUEEN ANNE'S

5. Social Security Number

212-20-2711

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

10/12/24

9. Birthplace (State or Foreign Country)

MARYLAND

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

STEVENSVILLE

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

501 BAYSIDE DRIVE

10f. Zip Code

21666

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BERNARD MCCOURT

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE MCFARLAND

19a. Informant's Name/Relationship (Type, Print)

CHARLES DAILEY, SR. / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 BAYSIDE DRIVE, STEVENSVILLE, MD 21666

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAKE MONT MEMORIAL GARDENS

Date

20c. Location - City or Town, State

05/04/2012

DAVIDSONVILLE, MD

21. Signature of Funeral Service Licensee

*S. K.*

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.  
106 SHAMROCK ROAD, CHESTER, MD 21619

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

14 mo

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Atherosclerosis*

*HTN*

*DM*

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?  
1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?  
1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

M 1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Jane Chamberlain*

29c. License number

D37064

29d. Date signed (Month, Day, Year)

9/30/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Jane Chamberlain, no 125 Shoreway Dr Queenstown MD 21658*

31. Date filed (Month, Day, Year)

*MAY-1 2012*

32. Registrar's Signature

*Jeanne B. Sparks*

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15450

**Physician/  
Medical Examiner****1- For State  
Registrar**

|   |  |   |  |  |                              |
|---|--|---|--|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vincenzo Anthony De Bari</b>                   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 7, 2012</b> | 3. Time of Death<br>1352 hrs |
| 4a. Facility Name (if not institution, give street and number)<br><b>5 Deepwater Court #M</b> |  | 4b. City, Town, or Location of Death<br><b>Cockeysville</b> |  | 4c. County of Death<br><b>Baltimore County</b>           |                              |

**Funeral  
Director**

|   |                          |   |   |  |  |   |
|---|--------------------------|---|---|--|--|---|
| 5. Social Security Number<br><b>058-46-9452</b> | 6. Sex<br><b>1 M 2 F</b> | 7. Age (In yrs. last birthday)<br><b>56</b><br>Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>07/14/1955</b> |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |
|---|--------------------------|---|---|--|--|---|

|                               |                                 |  |  |  |  |
|-------------------------------|---------------------------------|--|--|--|--|
| Usual Residence of Decedent   |                                 |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b> |  |  |
| 10a. State<br><b>Maryland</b> | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Cockeysville</b> |  |  |  |

|  |                               |   |
|--|-------------------------------|---|
| 10e. Street and Number<br><b>5 Deepwater Court</b> | 10f. Zip Code<br><b>21030</b> | 10g. Citizen of What Country?<br><b>USA</b> |
|--|-------------------------------|---|

|   |  |   |   |
|---|--|---|---|
| 11. Marital Status<br><b>1 Never Married 2 Married<br/>3 Widowed 4 Divorced</b> | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No specify:</b> | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |
|---|--|---|---|

|  |  |  |
|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Child Care Maintenance</b> | 16b. Kind of Business/Industry<br><b>Social Services</b> |
|--|--|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Carlo De Bari</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mafalda Galluzzo</b> |
|---|--|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carlo De Bari/ Father</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1642 Marlboro Rd., Edgewater, MD 21037</b> |
|--|--|

|  |  |                       |   |
|--|--|-----------------------|---|
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State<br/>4 Donation 5 Other Specify:</b> | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kalas Crematory</b> | Date<br><b>5/8/12</b> | 20c. Location - City or Town, State<br><b>Edgewater, MD</b> |
|--|--|-----------------------|---|

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b> | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>2973 Solomons Island Rd., Edgewater, MD 21037</b> |
|---|---|

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

|   |  |  |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | Approximate Interval Between Onset and Death |
|---|--|--|

|   |   |  |
|---|---|--|
| Immediate Cause (Final disease or condition resulting in death) | a. <b>Narcotic (Methadone) Intoxication</b><br>Due to (or as a consequence of): |  |
|---|---|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |  |  |
|--|--|--|
| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED 23a, pt.II, 27, 28a-f, per me, g927 5-29-12 sm |  |
|--|---|--|

|  |  |   |
|--|--|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 Yes 2 No 9 Unknown</b> | 23c. If yes, outcome of pregnancy<br><b>1 Live birth 2 Fetal death 3 Ectopic pregnancy<br/>4 Pregnant at time of death 5 Other (Specify)<br/>9 Unknown</b> | 23d. Date of delivery<br>Month Day Year |
|--|--|---|

|  |  |  |
|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |
|--|--|--|

|  |  |   |  |
|--|--|---|--|
| <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b> | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |
|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b> | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | 26. Place of Death (Check only one)<br><b>Other: 4 Nursing Home 5 Residence 6 Other: Scene</b> |  |
|---|--|--|--|

|   |  |  |   |   |
|---|--|--|---|---|
| 27. Manner of Death<br><b>1 Natural 5 Pending Investigation<br/>2 Accident 6 Could not be determined<br/>3 Suicide 4 Homicide</b> | 28a. Date of Injury (Month, Day, Year)<br><b>fd 5-7-12</b> | 28b. Time of Injury<br><b>fd 1:47 pm</b> | 28c. Injury at Work?<br><b>1 Yes 2 No</b> | 28d. Describe how injury occurred<br><b>Unknown</b> |
|---|--|--|---|---|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br><b>Residence</b> | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5 Deepwater Ct. #M Cockeysville, MD</b> |
|--|--|

|   |   |   |
|---|---|---|
| 29a. Certifier<br>(Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> | 29c. License number<br><b>O.C.M.E. OCME</b> | 29d. Date signed (Month, Day, Year)<br><b>May 8, 2012</b> |
|---|---|---|

|   |   |
|---|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> | 32. Registrar's Signature<br><b>[Signature]</b> |
|---|---|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> | 32. Registrar's Signature<br><b>[Signature]</b> |
|---|---|

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Within 24 hours after death.

To the

Funeral Director:

After

this certificate

has been

signed

by the

attending

physician

and

completely

filled

in by

the

funeral

director

page

2

should

be

detached

for

use

as the

burial

- transit

**State  
Registrar**

Donald Lee Evans

12-03415

Unk-Unk

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15451

## 1- For State Registrar

Physician/  
Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Donald Lee Evans</b>                               |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 3, 2012</b>   | 3. Time of Death<br>1026 hrs                     |
| 4a. Facility Name (if not institution, give street and number)<br><b>22425 Point Lookout Road</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b> |  |
| 5. Social Security Number<br><b>212-66-4917</b>   |  |  |  | 6. Sex<br><b>1 [X] M 2 [ ] F</b>                           | 7. Age (In yrs. last birthday)<br><b>57 Yrs.</b> |
| 8. If Under 1 Year<br>Months<br><b>04</b>   |  | If Under 24 Hrs.<br>Days<br><b>20</b>    |  | 9. Date of Birth (MM/DD/YYYY)<br><b>04/20/1955</b>         |  |
| 10. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                      |  | 11. County of Death<br><b>St. Mary's</b> |  | 12. Inside City Limits<br>1 [ ] Yes 2 [X] No               |  |

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

Physician /  
Medical Examiner

## To Be Completed by Funeral Director

## Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |   |
|--|--|---|--|---|--|---|
| Usual Residence of Decedent<br>10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>St. Mary's</b>  | 10c. City, Town or Location<br><b>Leonardtown</b>                | 10d. Inside City Limits<br>1 [ ] Yes 2 [X] No                           |
| 10e. Street and Number<br><b>22425 Point Lookout Road</b>  |  |   | 10f. Zip Code<br><b>20650</b>  |   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |
| 11. Marital Status<br>1 [ ] Never Married 2 [ ] Married  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 [ ] Yes 2 [X] No   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 [ ] Yes 2 [X] No |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)  |  | 16b. Kind of Business/Industry<br><b>Fuel and Ash Technician Natural Gas Service</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Floyd Evans</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Veronica Hill</b>  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah Carter/Sister</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>48226 Far cry Road, Lexington Park, MD 20653</b> |   |  |   |
| 20a. Method of Disposition<br>1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Brinsfield-Echols Cre</b>  |  | Date<br><b>05/09/2012</b>   | 20c. Location - City or Town, State<br><b>Charlotte Hall, MD</b> |   |
| 4 [ ] Donation 5 [ ] Other Specify:<br><b>Kathleen Santivasci M00872</b>   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A. 122955 Hollywood Road, Leonardtown, MD 20650</b>   |  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |
| a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):   |  |   |  |   |  |   |
| b. _____<br>Due to (or as a consequence of):   |  |   |  |   |  |   |
| c. _____<br>Due to (or as a consequence of):   |  |   |  |   |  |   |
| d. _____   |  |   |  |   |  |   |
| <input checked="" type="checkbox"/> UNPENDED   |  | <input type="checkbox"/> AMENDED 23a,27,per me,g927 5-16-12 sm  |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 [ ] Yes 2 [ ] No 9 [ ] Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy<br>4 [ ] Pregnant at time of death 5 [ ] Other (Specify)<br>9 [ ] Unknown |  |   | 23d. Date of delivery<br>Month Day Year                          |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown  |  |   |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 [X] Yes 2 [ ] No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other: Scene                |  |   |  |   |
| 27. Manner of Death<br>1 [X] Natural 5 [ ] Pending Investigation<br>2 [ ] Accident 6 [ ] Could not be determined<br>3 [ ] Suicide 4 [ ] Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury   | 28c. Injury at Work?<br>1 [ ] Yes 2 [ ] No                       | 28d. Describe how injury occurred                                       |
|  |  |   |  |   |  |   |
|  |  |   |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |
| 29a. Certifier 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br>2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |
| 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>May 4, 2012</b>               |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b>  |  | 32. Registrar's Signature<br>   |  |   |  |   |

State Registrar

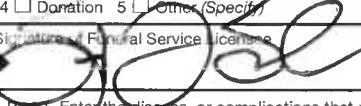
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2012 15452

1 - For  
State  
Registrar

|                                     |  |  |   |  |   |   |   |  |  |
|-------------------------------------|--|--|---|--|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA B. FOX</b>   |  |   |  |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>9</b> Year <b>2012</b>                             | 3. Time of Death<br><b>3:21 p M</b>  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>Elkton Care &amp; Rehab</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>138-03-0536</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Oct 2 1915</b> | 9. Birthplace (State or Foreign<br>Country)<br><b>New Jersey</b>                               |  |
|                                     | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Elkton</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br><b>68 South Shore Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21921</b>   |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |   | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>William Henry Gobright</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Shipley</b> |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Uhl (daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>32060 Mallard Lane Galena, MD. 21635</b>  |   |   |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kent Cremation Services</b> |   |   | Date<br><b>5/10/12</b>                                      | 20c. Location - City or Town, State<br><b>Smyrna, DE.</b>                                      |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen L. Schaech<br/>118 West Cross St. Galena, MD. 21635</b>   |   |   |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |   |   |  | Approximate Interval Between Onset and Death   |
|                                     | <p>a. <b>CARDIAC INRERSTITIAL LUNG DISEASE</b><br/>Due to (or as a consequence of):</p> <p>b. <b>CORONARY ARTERY DISEASE</b><br/>Due to (or as a consequence of):</p> <p>c. <b>DIVERTICULITIS OF COLON</b><br/>Due to (or as a consequence of):</p> <p>d. <b>HYPERTENSION</b></p>  |  |   |  |   |   |   |  |  |
|                                     | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |   |   |   |  | 23d. Date of delivery<br>Month Day Year  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENIA</b>   |  |   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred   |   |  |  |
|                                     |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |
|                                     | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>50007463</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-9-12</b>                        |   |  |  |
|                                     | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>50007463</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-9-12</b>                        |   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rolando Najera, M.D. 138 Cathedral St. Elkton, MD. 21921</b>  |  |   |  |   |   |   |  |  |
| State Registrar                     | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>  |  | 32. Registrar's Signature<br>  |  |   |   |   |  |  |

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
**Amend #8 per Fr g9417/16/13 TRT**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15453

1 - For  
State  
Registrar

|  |  |  |  |   |                                 |                          |  |   |  |  |
|--|--|--|--|---|---------------------------------|--------------------------|--|---|--|--|
| <b>Physician /Medical Examiner</b>   | 1. Decedent's Name (First, Middle, Last)   |  |  | 2. Date of Death<br>Month Day Year  |                                 |                          |  | 3. Time of Death  |  |  |
|  | <i>DIANE MYERS GALAMBOS</i>  |  |  | <i>APRIL 25 2012</i>  |                                 |                          |  | <i>1500 PM</i>  |  |  |
| <b>Funeral Director</b>  | 4a. Facility Name (If not institution, give street and number)   |  |  | 4b. City, Town, or Location of Death  |                                 |                          |  | 4c. County of Death   |  |  |
|  | <i>HARRISON SERVICE LIVING OF SNOW HILL</i>  |  |  | <i>SNOW HILL</i>  |                                 |                          |  | <i>WORCESTER</i>  |  |  |
| <b>To Be Completed by Funeral Director</b>   | 5. Social Security Number  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>44</i>   | If Under 1 Year<br>Months Days  |                          | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>8/22/1967</i>  | 9. Birthplace (State or Foreign Country)<br><i>PENNSYLVANIA</i>                                |  |
|  | Usual Residence of Decedent  |  | 10a. State<br><i>MARYLAND</i>  |   | 10b. County<br><i>WORCESTER</i> |                          | 10c. City, Town or Location<br><i>STOCKTON</i>                                   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| <b>To Be Completed by Funeral Director</b>   | 10e. Street and Number<br><i>729 SNOW HILL ROAD</i>  |  |  | 10f. Zip Code<br><i>21864</i>   |                                 |                          |  | 10g. Citizen of What Country?<br><i>USA</i>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><i>1980</i>  |                                 |                          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><i>WHITE</i> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i> |
| <b>Physician /Medical Examiner</b>   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12) 4 YEARS</i>   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>SCHOOL TEACHER</i>   |                                 |                          |  | 16b. Kind of Business/Industry<br><i>EDUCATION</i>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>ROBERT MYERS</i>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>CAROLE SORG</i>   |                                 |                          |  |   |  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><i>JOHN GALAMBOS</i>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>729 SNOW HILL ROAD STOCKTON, MARYLAND 21864</i>   |                                 |                          |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>ISLAND CREMATORIUM</i>   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>ISLAND CREMATORIUM</i>   |                                 |                          |  | Date<br><i>MAY 01 2012</i>  | 20c. Location - City or Town, State<br><i>CHINCOTEAGUE, VIRGINIA</i>                           |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 21. Signature of Funeral Service Licensee<br><i>► N. Dale Fox</i>  |  |  | 22. Name and Address of Facility<br><i>FOX &amp; HOLSTON FUNERAL HOME<br/>5049 CHICKENCITY ROAD CHINCOTEAGUE, VIRGINIA 23336</i>  |                                 |                          |  |   |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Breast Cancer</i>   |  |  |   |                                 |                          |  | Approximate Interval Between Onset and Death<br><i>8 yrs.</i>   |  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><i>9 Unknown</i>   |                                 |                          |  | 23d. Date of delivery<br>Month Day Year   |  |  |
|  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                 |                          |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><i>4 Nursing Home</i> |                                 |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  | 28a. Date of Injury<br>(Month, Day, Year)   |                                 | 28b. Time of Injury<br>M | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>At home</i>   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>Pocomoke, MD 21851</i>   |                                 |                          |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  | 29b. Signature and title of certifier<br><i>► Sarah R. Baral 4/26/12</i>  |                                 |                          |  | 29c. License number<br><i>154422</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>4/26/12</i>                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>SARAH R. BARAL, MD ; 1604 Market St. ; Pocomoke, MD 21851</i> |  |  | 31. Date filed (Month, Day, Year)<br><i>APR 26 2012</i>                    |   |                                 |                          | 32. Registrar's Signature<br><i>Sarah R. Baral</i>                               |   |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15454

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|                                     |  |  |   |  |  |  |  |  |   |   |  |
|-------------------------------------|--|--|---|--|--|--|--|--|---|---|--|
|                                     |  | 1. Decedent's Name (First, Middle, Last)<br><b>HAROLD RAYMOND GORDINIER</b>  |   |  |  |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>28</b> Year <b>2012</b>  |   | 3. Time of Death<br>12:50 P M                           |  |
|                                     |  | 4a. Facility Name (if not institution, give street and number)<br><b>GINGER COVE</b>   |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |   |   |  |
| Funeral<br>Director                 |  | 5. Social Security Number<br><b>484-09-7616</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | Hours  | Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/23/1921</b> | 9. Birthplace (State or Foreign Country)<br><b>IOWA</b> |  |
| To Be Completed by Funeral Director |  | Usual Residence of Decedent<br>MD ANNE ARUNDEL   |   | 10a. State<br>10b. County<br>10c. City, Town or Location<br><b>CROWNSVILLE</b>   |  |  |  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                     |  | 10e. Street and Number<br><b>1201 PENDERBROOKE COURT</b>   |   |  | 10f. Zip Code<br><b>21032</b>  |  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |   |  |
|                                     |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>      |  |   |   |  |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>4</b>      | 16b. Kind of Business/Industry<br><b>NAVAL AVIATOR</b>   |  |  | 16c. Kind of Business/Industry<br><b>UNITED STATES NAVY</b>                  |  |   |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM C. GORDINIER</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERNA THORNBERG</b>  |  |  |  |   |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PATRICK GORDINIER / SON</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1034 THOMPSON CREEK ROAD, STEVENSVILLE, MD 21666</b> |  |  |  |   |   |  |
|                                     |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>   |  |  | Date<br><b>05/05/2012</b>  | 20c. Location - City or Town, State<br><b>ACTON, MA</b>  |   |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br><i>Patrick G.</i>   |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A.<br/>106 SHAMROCK RD., CHESTER, MD 21619</b>   |  |  |  |  |   |   |  |
|                                     |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   |  | 23b. Due to (or as a consequence of):<br><b>Dementia</b>   |  |  | Approximate Interval Between Onset and Death   |   |   |  |
|                                     |  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  | 23d. Due to (or as a consequence of):  |  |  |  |   |   |  |
|                                     |  | 23e. Due to (or as a consequence of):  |   |  | 23f. Due to (or as a consequence of):  |  |  |  |   |   |  |
|                                     |  | 23g. Due to (or as a consequence of):  |   |  | 23h. Due to (or as a consequence of):  |  |  |  |   |   |  |
|                                     |  | 23i. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |  |  | 23d. Date of delivery<br>Month Day Year                                      |  |   |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|                                     |  |  |   |  |  |  |  | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|                                     |  |  |   |  |  |  |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
|                                     |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |   |   |  |
|                                     |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |  |  |   |   |  |
|                                     |  | 29b. Signature and title of certifier<br><i>Meddy</i>  |   | 29c. License number<br><b>D0058797</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/30/2012</b>                      |  |   |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Subashri S. Reddy<br/>2200 Defense Hwy Suite 103, Crofton, MD 21114</b>   |   |  |  |  |  |  |   |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY - 1 2012</b>   |   | 32. Registrar's Signature<br><i>Subashri S. Reddy</i>  |  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

54 ms

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15455

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

**Jerald James Humenik**2. Date of Death  
Month Day Year  
**May 8, 2012**3. Time of Death  
**0809 hrs****Funeral Director**

|  |  |  |
|--|--|--|
| 4a. Facility Name (if not institution, give street and number)<br><b>23828 Mervell Dean Road</b> | 4b. City, Town, or Location of Death<br><b>Hollywood</b> | 4c. County of Death<br><b>St. Mary's</b> |
|--|--|--|

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| 5. Social Security Number<br><b>212-66-3817</b> | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>56 Yrs.</b> | If Under 1 Year<br>Months Days Hours Min.<br><b></b> | 8. Date of Birth (MM/DD/YYYY)<br><b>04/22/1956</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|---|---|--|--|--|---|

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| Usual Residence of Decedent<br>10a. State<br><b>Maryland</b> 10b. County<br><b>St. Mary's</b> 10c. City, Town or Location<br><b>Hollywood</b> |  |  |  |  | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |
|---|--|--|--|--|---|

|  |                               |   |
|--|-------------------------------|---|
| 10e. Street and Number<br><b>23828 Mervell Dean Road</b> | 10f. Zip Code<br><b>20636</b> | 10g. Citizen of What Country?<br><b>U S A</b> |
|--|-------------------------------|---|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <b>White</b> | 14. Race - American Indian, Black, White, etc. |
|--|---|--|--|

|   |  |   |
|---|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b> | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>Plant Manager</b> | 16b. Kind of Business/Industry<br><b>Private School</b> |
|---|--|---|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>William Anthony Humenik</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Louise Hayden</b> |
|---|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Ann Nichalson/Sister</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44712 Deerfield Rd., Leonardtown, MD 20650</b> |
|---|--|

|  |  |                           |   |
|--|--|---------------------------|---|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Mattingley-Gardiner Funeral Home, P.A. Crematory</b> | Date<br><b>05/10/2012</b> | 20c. Location - City or Town, State<br><b>Leonardtown, MD</b> |
|--|--|---------------------------|---|

|   |  |
|---|--|
| 21. Signature of Funeral Service Licensee<br><b>Michael J. Gardiner</b> | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650</b> |
|---|--|

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 28-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician/  
Medical Examiner**

|  |   |  |
|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | e. <b>Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|---|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |  |  |
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| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |  |
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|  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g927 5-23-12 sm | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|---|

|  |  |                     |  |                                   |
|--|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|--|--|

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|--|--|---|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b> |
|--|--|---|

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|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b> | 32. Registrar's Signature<br><b>Anna S. Parker</b> |
|---|--|

**To Be Completed by Funeral Director**

|  |   |  |
|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | e. <b>Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|---|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
|--|--|--|

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| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |  |
|--|--|--|

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| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g927 5-23-12 sm | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

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| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

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|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|---|

|  |  |                     |  |                                   |
|--|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|--|--|

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|--|--|---|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b> |
|--|--|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b> | 32. Registrar's Signature<br><b>Anna S. Parker</b> |
|---|--|

**To Be Completed by Physician/Medical Examiner**

|  |   |  |
|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | e. <b>Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|---|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |  |  |
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| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, pt. II, 27, per me, g927 5-23-12 sm | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|---|--|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |
|---|---|

|  |  |                     |  |                                   |
|--|--|---------------------|--|-----------------------------------|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|--|--|---------------------|--|-----------------------------------|

|  |  |
|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|--|--|

|  |  |   |
|--|--|---|
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>May 9, 2012</b> |
|--|--|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|--|

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 2012</b> | 32. Registrar's Signature<br><b>Anna S. Parker</b> |
|---|--|

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15456

1 - For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAULINE MAE HENDERSON

2. Date of Death  
Month APRIL Day 29 Year 20123. Time of Death  
4:45 AMFuneral  
Director

4a. Facility Name (if not institution, give street and number)

556 THE POND WAY

4b. City, Town, or Location of Death

CHURCH HILL

4c. County of Death

QUEEN ANNE'S

5. Social Security Number

212-28-6591

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

SEPT. 8, 1932

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CHURCH HILL

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

556 THE POND WAY

10f. Zip Code

21623

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1  Yes 2  No Specify:14. Race - American Indian, Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9College (1-4 or 5+)  
-0-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES TATE

18. Mother's Name (First, Middle, Maiden Surname)

MARCELLA TROSTLE

19a. Informant's Name/Relationship (Type, Print)  
DEBORAH FERRIS/DAUGHTER19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
4132 DORIS AVENUE, BALTIMORE, MD 21225

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)20b. Place of Disposition (Name of cemetery, crematory or other place)  
CHESAPEAKE CREMATION CENTERDate  
APRIL 30, 201220c. Location - City or Town, State  
STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

►

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.  
408 S. LIBERTY ST., CENTREVILLE, MD 21617

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.   
Due to (or as a consequence of):Approximate Interval Between Onset and Death  
9 days

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):  
  
c.   
Due to (or as a consequence of):  
  
d.   
Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live Birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending Investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?  
1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

►

29c. License number

D0055127

29d. Date signed (Month, Day, Year)

4/29/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret D. Malaro M.D. 202 Courseyall Drive Centreville MD 21617

31. Date filed (Month, Day, Year)

APR 30 2012

32. Registrar's Signature

1-For State Amend Item 21 per fh, g927.05/15/2012dhb Certificate of Death

|  |  |   |   |   |   |  |   |  |  |
|--|--|---|---|---|---|--|---|--|--|
| <b>Physician/<br/>Medical Examiner</b>     | 1. Decedent's Name (First, Middle, Last)<br><b>Michele Renee Hamilton</b>  |   |   |   |   |  | 2. Date of Death<br>Month Day Year<br>April 13, 2012  | 3. Time of Death<br>1144 hrs   |  |
|  | Reg. No.   |   |   |   |   |  |   |  |  |
| <b>Funeral<br/>Director</b>                | 4a. Facility Name (if not institution, give street and number)<br><b>11 West Main Street Apt. 21</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Frostburg</b>  |   |  | 4c. County of Death<br><b>Allegany</b>  |  |  |
| To Be Completed by Funeral Director        | 5. Social Security Number<br><b>260-96-7713</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>55</b><br>Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth (MM/DD/YYYY)<br><b>10/18/1956</b> | 9. Birthplace (State or Foreign Country)<br><b>Texas</b>  |  |  |
|  | 10a. State<br><b>MD</b>  |   |   |   |   |  | 10b. County<br><b>Allegany</b>  | 10c. City, Town or Location<br><b>Frostburg</b>  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>11 West Main Street, Apt. 20</b>  |   |   | 10f. Zip Code<br><b>21532</b>   |   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |   |   |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Engineer</b>  |   |  | 16b. Kind of Business/Industry<br><b>Government</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Curtis Hamilton</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ruth Strangeways</b>   |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Holland Hamilton - daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 West Main Street, Apt. 1, Frostburg, MD 21532</b>  |   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cumberland Crematory</b>   | Date<br><b>04/15/2012</b>   | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>  |   |  |   |  |  |
| <b>Physician<br/>/Medical<br/>Examiner</b> | 21. Signature of Funeral Service Licensee<br><b>Alan M. Sowers per DVR</b>   |   |   | 22. Name and Address of Facility<br><b>Sowers Funeral Home, P.A.<br/>60 W. Main Street, Frostburg, MD 21532</b>   |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Verapamil intoxication</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |   |   |   |   |  |   | Approximate Interval Between Onset and Death   |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |   |   |   |  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA  |   | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |   |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Apr 13, 2012</b>  |   | 28b. Time of Injury<br><b>FOUND: 1130 hrs</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) <b>Multi-Family Apt.</b>  |   |   |  | 28d. Describe how injury occurred<br><b>unknown</b>   |  |  |
|  | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 14, 2012</b>                                    |  |  |
|  | 29b. Signature and title of certifier<br>   |   |   |   |   |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a)<br><b>Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |   |   |   |   |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b> 32. Registrar's Signature<br>   |   |   |   |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15458

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | Mildred Evelyn Myer   |   |  |  | 2. Date of Death<br>Month Day Year   | 3. Time of Death<br>9:20 A M   |
| 4a. Facility Name (if not institution, give street and number)  |  | Coastal Hospice at the Lake Salisbury   |   |  |  | 4c. County of Death<br>Wicomico  |  |
| 5. Social Security Number<br>205-16-3131  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs. | If Under 1 Year<br>Months Days Hours Min.  | If Under 24 Hrs.<br>Months Days Hours Min.                                       | 8. Date of Birth<br>03/12/1923   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |
| Usual Residence of Decedent<br>Maryland   |  | 10b. County<br>Wicomico   |   | 10c. City, Town or Location<br>Willards  |  |  |  |
| 10a. State<br>Maryland  |  | 10f. Zip Code<br>21874  |   |  |  | 10g. Citizen of What Country?<br>USA   |  |
| 10e. Street and Number<br>36053 Purnell Crossing Rd   |  |   |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) 4   |   | 16b. Kind of Business/Industry<br>Music Teacher  |  | Education  |  |
| 17. Father's Name (First, Middle, Last)<br>William Strickhouser   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Porter  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Gregory A. Myer/Son   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>36053 Purnell Crossing Rd., Willards, MD 21874   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Salisbury   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Salisbury Crematory   |   | Date<br>4/23/2012  | 20c. Location - City or Town, State<br>Salisbury, MD                             |  |  |
| 21. Signature of Funeral Service Licensee<br>David H. Thompson  |  | 22. Name and Address of Facility<br>Holloway Funeral Home Professional Association<br>501 Snow Hill Rd., Salisbury, MD 21804  |   |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)                      |   |  |  | Approximate Interval Between Onset and Death   |  |
| a. <i>Dementia</i><br>Due to (or as a consequence of):  |  |   |   |  |  |  |  |
| b. _____<br>Due to (or as a consequence of):  |  |   |   |  |  |  |  |
| c. _____<br>Due to (or as a consequence of):  |  |   |   |  |  |  |  |
| d. _____  |  |   |   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: _____   |   | 26. Place of Death (Check only one)<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|   |  |   |   |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  | 29d. Date signed (Month, Day, Year)<br>04/19/12  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br>D005840  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gregory WARS, P.O. Box 1733 SALISBURY MD 21802  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 26 2012  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2012 15459

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

|  |                                    |                  |
|--|------------------------------------|------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death |
| Mary Alice Matthews                      | 4 22 2012                          | 8:30 am          |

4a. Facility Name (If not institution, give street and number)

30360 Maple St, Apt 312

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

5. Social Security Number

218-34-9161

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)

7-15-1936

3. Time of Death  
Year

8:30 am

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified.  
and.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

|            |             |                             |  |
|------------|-------------|-----------------------------|--|
| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| MD         | Somerset    | Princess Anne               |  |

10e. Street and Number

30360 Maple St, Apt 312

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Home Nurse

16b. Kind of Business/Industry

Somerset Co.

Health Dept.

17. Father's Name (First, Middle, Last)

Howard W. Green

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Brown

19a. Informant's Name/Relationship (Type, Print)

David Wallace/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30360 Maple St, Apt 312, Princess Anne, MD 21853

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Direct Cremation

Date

4-26-2012

20c. Location - City or Town, State

Dover, DE

21. Signature of Funeral Service Licensee



22. Name and Address of Facility  
Bennie Smith 917 W. Isabella St.  
Funeral Home Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

ASCVD

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fatal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

26. Place of Death (Check only one)

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

218098

29d. Date signed (Month, Day, Year)

4/24/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vijay Kaumbharkar 201 Hall Highway, Griffield MD 21817

31. Date filed (Month, Day, Year)

APR 26 2012

32. Registrar's Signature



## REPLACEMENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend Items 10c,e,f, per inf., g928,06/13/2012 dmh

Certificate of Death

Reg. No. 2012 15460

|  |  |   |  |   |   |   |  |  |
|--|--|---|--|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Florence W. McDannell</b>   |   |  |   | 2. Date of Death<br>Month 4 Day 26 Year 12  | 3. Time of Death<br>5:15 p.m.   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>186-36-3173</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs.<br><b>94</b>  | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>4/16/1918</b>                | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |
|  | Usual Residence of Decedent<br><b>Anne Arundel</b>   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Gambrills</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                         |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>1262 Defense Highway</b>  |   |  | 10f. Zip Code<br><b>21054</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                               |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: <input checked="" type="checkbox"/> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>   |   | 16b. Kind of Business/Industry<br><b>Elementary School</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Blaine Waddle</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Belle Baker</b>   |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. Keller - daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2071 Ingleside Court Crofton, MD 21114</b>   |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PA Cremation Society of</b>   |   | Date<br><b>5/2/2012</b>   | 20c. Location - City or Town, State<br><b>King of Prussia, Pa</b>         |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Auer Cremation Services of Pa.<br/>4100 Jonestown Road Harrisburg, Pa 17109</b>   |   |   |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Approximate Interval Between Onset and Death<br><b>weeks</b>  |   |  |   |   |   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br><b>Pneumonia</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><i>CERTIFICATION APPROVED BY MEDICAL EXAMINER</i>  |   |  |   |   |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____ |   |   |   | 23d. Date of delivery<br>Month Day Year  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure<br/>12.5 Fractures T4-T8</b>   |   |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Home</b> |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of Injury<br>(Month, Day, Year)<br><b>4/11/12</b>  | 28b. Time of Injury<br><b>Unknown</b>   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred<br><b>Patient fell walking in home.</b> | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1262 Defense Hwy, Gambrills, MD</b> |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |  |
|  | 29b. Signature and title of certifier<br><i>Eva S. Hersh MD</i>  |   | 29c. License number<br><b>MD D0036581</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/29/12</b>   |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Eva Hersh MD 445 Defense Highway ANNAPOLIS, MD 21401</b>  |   |  |   |   |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUN 13 2012</b>  |   | 32. Registrar's Signature<br><i>Susan B. Parker</i>  |   |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

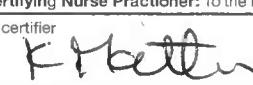
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15461

1 - For  
State  
Registrar

|  |   |   |   |   |   |  |  |  |  |
|--|---|---|---|---|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT CRAIG MATHEWS JR.</b>   |   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>5</b> Year <b>2012</b> | 3. Time of Death<br><b>5:45A M</b>   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>14974 POTOMAC RIVER DRIVE</b>  |   |   | 4b. City, Town, or Location of Death<br><b>COBB ISLAND</b>  |   | 4c. County of Death<br><b>CHARLES</b>                              |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-56-2877</b>   | 6. Sex<br><b>M</b>  | 7. Age (In yrs. last birthday)<br><b>68 Yrs.</b>  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours   | 8. Date of Birth<br>(Month, Day, Year)<br><b>JUL. 2, 1943</b>      | 9. Birthplace (State or Foreign Country)<br><b>MISSISSIPPI</b>                                 |  |  |
|  | Usual Residence of Decedent   |   |   | 10a. State<br><b>MD</b> 10b. County<br><b>CHARLES</b> 10c. City, Town or Location<br><b>COBB ISLAND</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>14974 POTOMAC RIVER DRIVE</b>  |   |   | 10f. Zip Code<br><b>20625</b>   |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>                   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STAGE HAND</b>  |   |   | 16b. Kind of Business Industry<br><b>KENNEDY CENTER</b>            |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT CRAIG MATHEWS SR.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JEAN SHIRLEY MC NAIR</b>  |   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BERNADETTE MATHEWS/SPOUSE</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14974 POTOMAC VIEW DR., COBB ISLAND, MD 20625</b> |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO.CREMATORY</b>  | <b>MAY</b> Date<br><b>8, 2012</b>   | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VA</b>  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility <b>RAYMOND FUNL. SERVICE, P.A.</b><br><b>5635 WASHINGTON AVE., LA PLATA, MD 20646</b>  |   |   |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |  |
|  | <p>a. Due to (or as a consequence of):<br/><i>Cancer of Tonsils</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |   |   |   |   |  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year                            |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |   |   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | Hospital: _____   |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28d. Describe how injury occurred                                  |  |  |  |
|  |   |   |   |   |   |  |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |  |  |  |
|  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D23582</b>  |   |   | 29d. Date signed (Month, Day, Year)<br><b>5-7-12</b>               |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>P O Box 1703 La Plata MD 20646</b>   |   |   |   |   |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |   | 32. Registrar's Signature<br>  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2011

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15462

2. Date of Death

Month

Day

Year

3. Time of Death

04 24 2012 3320P M

**1-** For  
State  
Registrar

**Physician/  
Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Floe Nock</b>   |  |   | 2. Date of Death  |   | 3. Time of Death   |
|  |  |   | Month   | Day   | Year   |
|  |  |   | 04  | 24  | 2012   |
|  |  |   | 4. City, Town, or Location of Death<br><b>SALISBURY</b>   |   | 5. County of Death<br><b>Wicomico</b>                    |
| 6. Sex<br><b>M</b>   |  |   | 7. Age (In yrs. last birthday)<br><b>66</b>   |   | 8. Date of Birth (Month, Day, Year)<br><b>06/07/1945</b> |
| 9. Social Security Number<br><b>494-48-9150</b>  |  |   | Months  | Days  | Hours Min.   |
| 10a. State<br><b>Maryland</b>  |  |   | 10b. County<br><b>Wicomico</b>  |   | 10c. City, Town or Location<br><b>Pittsville</b>         |
| 10d. Inside City Limits<br><b>Yes</b>  |  |   | 10e. Street and Number<br><b>7497 Truitt St.</b>  |   |  |
| 10f. Zip Code<br><b>21850</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><b>Widowed</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>No</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>No</b>   |  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b> |  |
| 16b. Kind of Business/Industry<br><b>Head Start</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Willard Nynun Williams</b>                              |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alma Floe Roberts</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cherie D. Gilmore /Daughter</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>208 E. State St., Delmar, MD 21875</b>                                      |   |  |
| 20a. Method of Disposition<br><b>Cremation</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |   | Date<br><b>4/26/2012</b>                                 |
| 21. Signature of Funeral Service Licensee<br><b>David J. Thompson CFSP</b>   |  |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   | Approximate Interval Between Onset and Death<br><br><b>ASCVD</b>  |   |  |
| a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):   |  |   |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>No</b>   |  |   | 23c. If yes, outcome of pregnancy<br><b>Live Birth</b> <b>Fetal death</b> <b>Ectopic pregnancy</b><br><b>Pregnant at time of death</b> <b>Other (specify)</b><br><b>Unknown</b> |   |  |
| 23d. Date of delivery<br>Month   Day   Year  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>No</b>   |   |  |
|  |  |   | 24a. Was an autopsy performed?<br><b>No</b>   |   |  |
|  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>No</b>  |   |  |
| 25. Was case referred to medical examiner?<br><b>No</b>  |  |   | 26. Place of Death (Check only one)<br><b>Inpatient</b>   |   |  |
| Hospital:<br><b>1</b>  |  |   | Other:<br><b>4 Nursing Home</b>   |   |  |
| 27. Manner of Death<br><b>Natural</b>  |  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury   | 28c. Injury at work?<br><b>Yes</b>                       |
| 2 <b>Pending Investigation</b><br>3 <b>Accident</b><br>4 <b>Homicide</b>   |  |   | <b>M</b>  | <b>No</b>   | 28d. Describe how injury occurred                        |
| 5 <b>Could not be determined</b>   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
|  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier<br><b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>M. THIMMARA YAPPA</b>  |  |   | 29c. License number<br><b>D605L</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/25/12</b>    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. THIMMARA YAPPA 910 EASTERN SHORE DR., SALISBURY MD 21804</b>   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  |   | 32. Registrar's Signature<br><b>Debra S. Sparta</b>   |   |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15463

**1- For State Registrar****Physician/  
Medical Examiner**

|  |                                    |                              |
|--|------------------------------------|------------------------------|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death<br>Month Day Year | 3. Time of Death<br>1830 hrs |
|--|------------------------------------|------------------------------|

Lauren Elizabeth O'Connell

May 5, 2012

1830 hrs

|   |   |                     |
|---|---|---------------------|
| 4a. Facility Name (if not institution, give street and number)<br>University Hospital | 4b. City, Town, or Location of Death<br>Baltimore | 4c. County of Death |
|---|---|---------------------|

**Funeral Director**

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 5. Social Security Number<br>214-31-1023 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>23 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>06/09/1988 | 9. Birthplace (State or Foreign Country)<br>MD |
|--|--|---|---|---|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| Usual Residence of Decedent<br>10a. State<br>MD 10b. County<br>Frederick 10c. City, Town or Location<br>Frederick |  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|---|--|--|--|--|--|

|  |                        |  |
|--|------------------------|--|
| 10e. Street and Number<br>3809 Kendall Drive | 10f. Zip Code<br>21704 | 10g. Citizen of What Country?<br>United States |
|--|------------------------|--|

|  |   |   |  |
|--|---|---|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: White | 14. Race - American Indian, Black, White, etc. |
|--|---|---|--|

|  |  |  |
|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>4 Financial services | 16b. Kind of Business/Industry<br>Retirement Accts |
|--|--|--|

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>Daniel R. O'Connell | 18. Mother's Name (First, Middle, Maiden Surname)<br>Leslie Joanne Roesser |
|--|--|

|   |  |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Daniel O'Connell / father | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3809 Kendall Drive, Frederick, MD 21704 |
|---|--|

|  |  |                 |  |
|--|--|-----------------|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Mem. Gardens | Date<br>5/12/12 | 20c. Location - City or Town, State<br>Frederick, MD |
|--|--|-----------------|--|

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br><i>Debra Lee Krebs</i> | 22. Name and Address of Facility<br>Keeney & Basford Funeral Home<br>106 E. Church St., Frederick, MD 21701 |
|---|---|

**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

|  |  |  |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | a. Multiple Injuries<br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death |
|--|--|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  |
|--|--|--|

|  |  |  |
|--|--|--|
| c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |  |
|--|--|--|

|                                   |                                  |  |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED |  |
|-----------------------------------|----------------------------------|--|

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
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|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
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| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other. |  |  |
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|---|---|---------------------------------|---|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>May 5, 2012 | 28b. Time of Injury<br>1647 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br>Subject jumped from building |
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| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Parking Garage | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>4515 Painters Mill Road, Owings Mills, MD |
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| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Mary G. Ripple MD</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>May 6, 2012 |
|---|---|---------------------------------|--|

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|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
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| 31. Date filed (Month, Day, Year)<br>MAY 15 2012 | 32. Registrar's Signature<br><i>Anne S. Parker</i> |
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**Division of Vital Records, P.O. Box 68760,**

The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial - transit

completely filled in by the funeral director.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any

injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15464

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |  |   |   |   |                          |  |  |   |  |
|--|--|---|---|---|--------------------------|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET ANN ROZANKOWSKI</b>  |  |   |   | 2. Date of Death<br>Month<br>APRIL  | Day<br>23                | Year<br>2012   | 3. Time of Death<br>10:35 A M  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |                          |  | 4c. County of Death<br><b>WORCESTER</b>  |   |  |
| 5. Social Security Number<br><b>213-30-0095</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>78 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days | 8. Date of Birth<br>(Month, Day, Year)<br><b>MAR. 12, 1934</b>                   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |   |  |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>WORCESTER</b>   |   | 10c. City, Town or Location<br><b>OCEAN CITY</b>  |                          |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>185 CLAM SHELL ROAD</b>   |  |   |   | 10f. Zip Code<br><b>21842</b>   |                          |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>WHITE</b> |                          |  | 14. Race - American Indian, Black, White, etc.   |   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |                          |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>THOMAS MACDOUGALL</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AGNES WILLIS</b>  |                          |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOHN A. ROZANKOWSKI/HUSBAND</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>185 CLAM SHELL ROAD, OCEAN CITY, MD 21842</b>   |                          |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>CREMATORIAL OF DELMARVA</b>  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CREMATORIAL OF DELMARVA</b>  |                          | Date<br><b>4/26/12</b>   | 20c. Location - City or Town, State<br><b>DELMAR, DELAWARE</b>                                 |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>   |                          |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>bronchogenic cancer</b><br>Approximate Interval Between Onset and Death<br><b>3 years</b>   |  |   |   |   |                          |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><b>bronchogenic cancer</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |   |   |                          |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |   |                          | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |                          |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |   |                          |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                          |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |   | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><b>D</b>                             |                          |  |  |   |  |
| 27. Manner of Death<br><b>Natural</b><br><input type="checkbox"/> Accident<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>M</b>   |   | 28b. Time of injury<br><b>M</b>   |                          | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                     |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>9733 Hwy 1 Hwy 7 Dr. ne</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Berlin, Md</b>   |   |   |                          |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>144283</b>  |   |   |                          |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/23/12</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert P. Durkin</b>  |  |   |   |   |                          |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br><b>Suzanne P. Parker</b>   |   |   |                          |  |  |   |  |

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15465

1 - For  
State  
Registrar

|  |  |   |  |  |  |   |   |  |   |  |
|--|--|---|--|--|--|---|---|--|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>ALICE LEE SMITH</b>   |   |  |  |  | 2. Date of Death<br>Month<br><b>APRIL</b>   | Day<br><b>25</b>  | Year<br><b>2012</b>  | 3. Time of Death<br><b>11:17 AM</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |   |  |  |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |   |  | 4c. County of Death<br><b>WORCESTER</b>   |  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>214-10-8350</b>  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (in yrs. last birthday)<br><b>92 Yrs.</b>   | If Under 1 Year<br>Months<br><b></b>   | If Under 24 Hrs.<br>Days<br><b></b>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>JAN. 16, 1920</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                 |  |   |  |
| To Be Completed by Funeral Director        | 10a. State<br><b>DELAWARE</b>  | 10b. County<br><b>SUSSEX</b>  | 10c. City, Town or Location<br><b>SELBYVILLE</b>   | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                                |  |   |   |  |   |  |
|  | 10e. Street and Number<br><b>29 POLLY BRANCH ROAD</b>  |   |  | 10f. Zip Code<br><b>19975</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.</b> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |   |   | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>     |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>CAFETERIA MANAGER</b> |  |   | 16b. Kind of Business/Industry<br><b>SCHOOL DISTRICT</b>                                    |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL T. JONES</b>  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAMIE E. JONES</b>  |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>G. FRANK SMITH III/SON</b>  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>31 POLLY BRANCH ROAD, SELBYVILLE, DE. 19975</b> |   |  |   |  |
|  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>REDMEN'S CEMETERY</b>                                       |  |   | Date<br><b>4/28/12</b>  | 20c. Location - City or Town, State<br><b>SELBYVILLE, DELAWARE</b> |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Charles W. Hastings</b>  |   |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>  |  |   |   |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b> | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive heart failure</b>  |   |  |  |  |   |   |  | Approximate Interval Between Onset and Death  |  |
|  | a. Due to (or as a consequence of):<br><b>Congestive heart failure</b>   |   |  |  |  |   |   |  |   |  |
|  | b. Due to (or as a consequence of):  |   |  |  |  |   |   |  |   |  |
|  | c. Due to (or as a consequence of):  |   |  |  |  |   |   |  |   |  |
|  | d. _____   |   |  |  |  |   |   |  |   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b> |  |  |   |   | 23d. Date of delivery<br>Month Day Year                            |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
|  |  |   |  |  |  |   |   |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |
|  |  |   |  |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  |
|  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |   | Hospital:<br><b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>   |  | Other:<br><b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>   |   | 26. Place of Death (Check only one)   |  |   |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>   |   | 28a. Date of injury<br>(Month, Day, Year)<br><b></b>   |  | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  | 28d. Describe how injury occurred   |  |
|  | 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  | 29a. Certifier<br>(Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |  |  |   |   |  |   |  |
|  | 29b. Signature and title of certifier<br><b>Andrea K Barr MD</b>   |   | 29c. License number<br><b>DS3612</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/25/12</b>  |   |   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrea K Barr MD 9733 Healthway Dr Berlin MD 21811</b>  |   |  |  |  |   |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |   | 32. Registrar's Signature<br><b>Andrea K. Barr</b>   |  |  |   |   |  |   |  |

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15466

**1- For State Registrar**

1. Decedent's Name (First, Middle, Last)

Lydia Ann Steenrod

2. Date of Death

Month

Day

Year

May 3, 2012

3. Time of Death

1451 hrs

**Physician/Medical Examiner**

4a. Facility Name (if not institution, give street and number)

23118 Old Pine Court

4b. City, Town, or Location of Death

California

4c. County of Death

St. Mary's

**Funeral Director**

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or Foreign Country)

214-17-0751

M

F

29

Yrs.

Months

Days

Hours

Min.

12/16/1982

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland

St. Mary's

California

1  Yes 2  No**To Be Completed by Funeral Director**

10e. Street and Number

23118 Old Pine Court

10f. Zip Code

10g. Citizen of What Country?

20619

United States

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

12

Salesperson

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Randall Wood Steenrod

18. Mother's Name (First, Middle, Maiden Surname)

Vicki Ann Studevant

19a. Informant's Name/Relationship (Type, Print)

Randall W. Steenrod/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48363 Leachburg Road, Lexington Park, MD 20653

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Charles Memorial Cem.

Date

20c. Location - City or Town, State

05/12/2012 Leonardtown, MD

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. **Cardiac Arrhythmia**

Due to (or as a consequence of):

b. **Cardiomegaly**

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

 UNPENDED AMENDED 23a-b, 27, per me, g929 7-10-12 sm

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  NoHospital: 1  Inpatient 2  ER/Outpatient 3  DOA4  Nursing Home 5  Residence 6  Other: Scene

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation6  Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 4, 2012

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State

Registrar

31. Date filed (Month, Day, Year)

MAY 09 2012

32. Registrar's Signature

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, MD 21215-0036**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

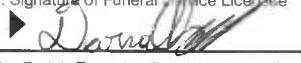
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15467

1- For  
State  
Registrar

Reg. No.

Physician/  
Medical  
Examiner

|  |  |   |                                |   |   |   |   |  |   |
|--|--|---|--------------------------------|---|---|---|---|--|---|
| 1. Physician/Medical Examiner                    |  | 1. Decedent's Name (First, Middle, Last)<br><b>Sherry Jean Turner</b>   |                                |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>20</b> Year <b>2012</b>   |   | 3. Time of Death<br><b>0824 A.M.</b>   |   |
| 2. Funeral Director                              |  | 4a. Facility Name (if not institution, give street and number)<br><b>PENNSYLVANIA REGIONAL MEDICAL CENTER</b>   |                                |   |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |   | 4c. County of Death<br><b>WICOMICO</b>   |   |
| 3. To Be Completed by Physician/Medical Examiner |  | 5. Social Security Number<br><b>214-80-7453</b><br>Usual Residence of Decedent  |                                | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>   | 7. Age (In yrs. last birthday)<br><b>50</b><br>Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br><b>7-25-1961</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|  |  | 10a. State<br><b>MD</b>   | 10b. County<br><b>WICOMICO</b> | 10c. City, Town or Location<br><b>Salisbury</b>   |   |   |   | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |
|  |  | 10e. Street and Number<br><b>733 Hemlock Street</b>   |                                |   |   | 10f. Zip Code<br><b>21804</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|  |  | 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>       |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify Black</b>   |   |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |                                |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>CNA</b>  |   | 16b. Kind of Business/Industry<br><b>Johns Hopkins Hosp</b>  |   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Willie Bell Turner, Sr.</b>   |                                |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gloria Jean Turner Jones</b>  |   |  |   |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Turner/Brother</b>   |                                |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4605 Church St, Vienna, MD 21869</b>  |   |  |   |
|  |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wesley UM Cem</b>  |   | Date<br><b>4-28-2012</b>  | 20c. Location - City or Town, State<br><b>Vienna, MD</b>                                    |  |   |
|  |  | 21. Signature of Funeral Service Licensee<br>  |                                |   |   | 22. Name and Address of Facility<br><b>PO Box 326<br/>McPherson Fun Ser Milford, DE 19963</b>   |   |  |   |
|  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CARDIOMYOPATHY</b>   |                                |   |   | Approximate Interval Between Onset and Death<br><b>months</b>   |   |  |   |
|  |  | b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):   |                                |   |   | Approximate Interval Between Onset and Death<br><b>years</b>  |   |  |   |
|  |  | c. Due to (or as a consequence of):   |                                |   |   |   |   |  |   |
|  |  | d. Due to (or as a consequence of):   |                                |   |   |   |   |  |   |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>3 <input type="checkbox"/> Unknown</b>  |                                | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br/>9 <input type="checkbox"/> Unknown</b>      |   |   |   | 23d. Date of delivery<br>Month Day Year  |   |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                |   |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b> |   |  |   |
|  |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |                                | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |   |   |   | 24a. Was an autopsy performed?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |   |
|  |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br/>4 <input type="checkbox"/> Homicide</b>  |                                | 28a. Date of injury<br>(Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred  |   |
|  |  |   |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
|  |  | 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                                | 29c. License number<br><b>D38353</b>  |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>April 21, 2012</b>   |   |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rene Desmarais, M.D. 400 E Shore Dr. SALISBURY MD</b>  |                                |   |   |   |   |  |   |
|  |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>   |                                | 32. Registrar's Signature<br>  |   |   |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

STC  
State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 25 per me, g927, 05/11/2012dhp

Certificate of Death

Reg. No.

2012 15468

|   |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|
| Physician/<br>Medical<br>Examiner             |  | 1. Decedent's Name (First, Middle, Last)<br><b>Timothy N Tabor</b>   |  |  |  |   |  |  |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>4</b> Year <b>2012</b>                                     |  | 3. Time of Death<br>04:07 AM                                  |  |
| Funeral<br>Director                           |  | 4a. Facility Name (if not institution, give street and number)<br><b>University of Maryland Medical Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |  |  | 4c. County of Death  |  |  |  |   |  |
| To Be Completed by Funeral Director           |  | 5. Social Security Number<br><b>227-90-7364</b>  |  | 6. Sex<br><b>1 X M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>56</b><br>Yrs.   |  | If Under 1 Year<br>Months  |  | If Under 24 Hrs.<br>Hours  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 29, 1956</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>California</b> |  |
| To Be Completed by Physician/Medical Examiner |  | 10a. State<br><b>VA</b>  |  | 10b. County<br><b>Northampton</b>  |  | 10c. City, Town or Location<br><b>Machipongo</b>  |  |  |  |  |  | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 10e. Street and Number<br><b>5390 Harmantown Road</b>  |  |  |  | 10f. Zip Code<br><b>23405</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 11. Marital Status<br><b>1 □ Never Married 2 X Married<br/>3 □ Widowed 4 X Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 □ Yes 2 X No</b><br>If Yes, Give Year or Dates.    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 □ Yes 2 X No</b> Specify:<br><b>White</b>               |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b><br><b>2</b><br><b>police officer</b> |  | 16b. Kind of Business/Industry<br><b>Chesapeake Bay Bridge Tunnel District</b>                       |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 17. Father's Name (First, Middle, Last)<br><b>Malcolm N. Tabor</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Reba L. Minor</b>   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Malcolm G. Tabor - brother</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3231 Eberwine Lane, Suffolk, VA 23435</b>                                   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 20a. Method of Disposition<br><b>1 □ Burial 2 X Cremation 3 □ Removal from State<br/>4 □ Donation 5 □ Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Occohannock Crematory</b> |  | Date<br><b>3/7/2012</b>   |  | 20c. Location - City or Town, State<br><b>Exmore, Virginia</b>                                       |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 21. Signature of Funeral Service Licensee<br><b>Jerry J. Daugherty</b>   |  | 22. Name and Address of Facility<br><b>Doughty Funeral Home, Inc. Exmore, VA 23350</b>                 |  |   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | <p>a. <b>Gastrointestinal tract bleeding</b><br/>Due to (or as a consequence of):<br/><b>PERFORATION OF DUODENAL POUCH ULCER</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |  |  |  |   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | IF FEMALE:   |  | 23b. Was decedent pregnant in the past 12 months?<br><b>1 □ Yes 2 □ No<br/>g □ Unknown</b>             |  | 23c. If yes, outcome of pregnancy<br><b>1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy<br/>4 □ Pregnant at time of death 5 □ Other (Specify)<br/>g □ Unknown</b>          |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</b> |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><b>1 X Yes 2 □ No</b>  |  | Hospital:<br><b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DDA</b>  |  | Other:<br><b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>   |  | 23f. Were autopsy findings available prior to completion of cause of death?<br><b>1 □ Yes 2 X No</b> |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 27. Manner of Death<br><b>1 X Natural 5 □ Pending Investigation<br/>2 □ Accident 6 □ Could not be determined<br/>3 □ Suicide 4 □ Homicide</b>  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><b>1 □ Yes 2 □ No</b>  |  | 28d. Describe how injury occurred  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 29a. Certifier<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>(Check only one)<br/>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                 |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 29b. Signature and title of certifier<br><b>M.D.</b>   |  | 29c. License number<br><b>P27462</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Mar 4, 2012</b>   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>E.W. WANG M.D. University of Medical Center</b>   |  |  |  |   |  | 27 South Greene St<br>Baltimore, MD  |  |  |  |  |  |   |  |
| State Registrar                               |  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>  |  | 32. Registrar's Signature<br><b>Susan A. Parker</b>  |  |   |  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

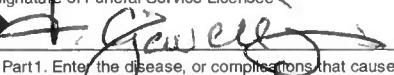
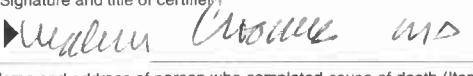
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

**Reg. No.**

2012 15469  
Time of Death

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| <b>Baltimore, Maryland 21215-0036</b><br><b>Division of Vital Records, P.O. Box 68760,</b><br><b>Physician /Medical Examiner</b> |  | 1. Decedent's Name (First, Middle, Last)<br><b>Willa B. Wilson</b><br>2. Date of Death<br>Month Day Year<br><b>April 25, 2012</b> 7:58A <sup>M</sup><br>3. Time of Death  |  |  |  |  |  |  |
| <b>Funeral Director</b>  |  | 4a. Facility Name (If not institution, give street and number)<br><b>25209 Rewastico Road</b><br>4b. City, Town, or Location of Death<br><b>Hebron</b><br>4c. County of Death<br><b>Wicomico</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 5. Social Security Number<br><b>216-16-7008</b> 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday)<br><b>98 Yrs.</b> If Under 1 Year If Under 24 Hrs.<br>Months Days Hours Min.<br>8. Date of Birth (Month, Day, Year)<br><b>Feb. 13, 1914</b> 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | Usual Residence of Decedent<br>10a. State<br><b>MD</b> 10b. County<br><b>Wicomico</b> 10c. City, Town or Location<br><b>Hebron</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 10e. Street and Number<br><b>25209 Rewastico Road</b> 10f. Zip Code<br><b>21830</b> 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br>13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br>14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>8</b> seamstress 16b. Kind of Business/Industry<br><b>garment company</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>George Henry Bounds</b> 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Robinson</b>   |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dick Wilson (Son)</b> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25283 Rewastico Road Hebron, MD 21830</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Stephens Cemetery Park</b> Date<br><b>4-27-2012</b> 20c. Location - City or Town, State<br><b>Delmar, Delaware</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>   |  | 21. Signature of Funeral Service Licensee<br> 22. Name and Address of Facility<br><b>Short Funeral Home</b><br><b>13 East Grove Street Delmar, DE 19940</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | a. <b>Failure to thrive,</b><br>Due to (or as a consequence of):<br>b. <b>Arteriosclerosis</b> ,<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | Approximate Interval Between Onset and Death  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death<br>9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy<br>5 <input type="checkbox"/> Other (specify) _____  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 29b. Signature and title of certifier<br> 29c. License number<br><b>D 32014</b> 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Walter J. Crowley 106 Carroll St. SBY 13 Salisbury MD 27804</b>  |  |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b> 32. Registrar's Signature<br>  |  |  |  |  |  |  |

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

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**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend #20b Per FB G927 5/31/2012 Jh

State of Maryland / Department of Health and Mental Hygiene

1 - For  
State  
Registrar

Certificate of Death

Reg. No. 2012 15470

Physician/  
Medical  
Examiner

|  |  |  |   |  |  |                                       |
|--|--|--|---|--|--|---------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE WALKER</b>                           |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>24</b> Year <b>2012</b> |  |  | 3. Time of Death<br><b>6:15 AM</b>    |
| 4a. Facility Name (if not institution, give street and number)<br><b>417 GARNER AVENUE</b> |  |  | 4b. City, Town, or Location of Death<br><b>WALDORF</b>            |  |  | 4c. County of Death<br><b>CHARLES</b> |

Funeral  
Director

|   |  |                    |  |                                     |                                     |  |  |
|---|--|--------------------|--|-------------------------------------|-------------------------------------|--|--|
| 5. Social Security Number<br><b>229-38-0245</b> |  | 6. Sex<br><b>M</b> | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months      Days | If Under 24 Hrs.<br>Hours      Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>5/20/1936</b> | 9. Birthplace (State or Foreign Country)<br><b>NORFOLK, VA</b> |
|---|--|--------------------|--|-------------------------------------|-------------------------------------|--|--|

|                               |                               |   |  |  |  |  |                                      |
|-------------------------------|-------------------------------|---|--|--|--|--|--------------------------------------|
| 10a. State<br><b>MARYLAND</b> | 10b. County<br><b>CHARLES</b> | 10c. City, Town or Location<br><b>WALDORF</b> |  |  |  |  | 10d. Inside City Limits<br><b>No</b> |
|-------------------------------|-------------------------------|---|--|--|--|--|--------------------------------------|

|  |  |  |                               |  |  |   |  |
|--|--|--|-------------------------------|--|--|---|--|
| 10e. Street and Number<br><b>417 GARNER AVENUE</b> |  |  | 10f. Zip Code<br><b>20602</b> |  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b> |  |
|--|--|--|-------------------------------|--|--|---|--|

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1974</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: BLACK</b> | 14. Race - American Indian, Black, White, etc.<br><b>BLACK</b> |
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|   |  |  |
|---|--|--|
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b> | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+) 4 MORTGAGE BANKER</b> | 16b. Kind of Business/Industry<br><b>FINANCE</b> |
|---|--|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>WILLIE WALKER</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LUCILE STEWART</b> |
|---|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BARBARA WALKER/WIFE</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 GARNER AVENUE WALDORF, MD 20602</b> |
|--|---|

|   |  |   |
|---|--|---|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON NATIONAL CEMETERY</b> | 20c. Location - City or Town, State<br><b>ARLINGTON, VA</b> |
|---|--|---|

|  |   |
|--|---|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br><b>LASTING TRIBUTES BY FELLOWS<br/>HELFENBEIN &amp; NEWMAN CREMATION &amp; FUNERAL CARE<br/>814 BESTGATE ROAD ANNAPOLIS, MD 21401</b> |
|--|---|

|  |   |   |   |
|--|---|---|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 23c. Due to (or as a consequence of):<br><b>SOFT TISSUE Neoplasm.</b> | 23d. Approximate Interval Between Onset and Death |
|  |   | b. Due to (or as a consequence of):<br><b>colon cancer</b>            |   |
|  |   | c. Due to (or as a consequence of):                                   |   |
|  |   | d. _____  |   |

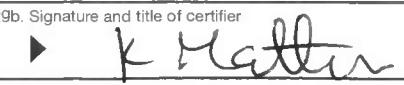
|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>g <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|--|--|

|  |   |
|--|---|
| 23f. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
|--|---|

|  |  |                     |  |  |
|--|--|---------------------|--|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

|   |
|---|
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|---|

|  |                                      |   |
|--|--------------------------------------|---|
| 29b. Signature and title of certifier<br> | 29c. License number<br><b>D28352</b> | 29d. Date signed (Month, Day, Year)<br><b>4/26/12</b> |
|--|--------------------------------------|---|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Po Box 1703</b> | 32. Registrar's Signature<br><b>K. Mattern</b> |
|--|--|

|   |
|---|
| 31. Date filed (Month, Day, Year)<br><b>APR 30 2012</b> |
|---|

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

State  
Registrar

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

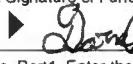
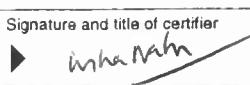
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15471

1- For  
State  
Registrar

|  |  |  |   |  |  |  |   |  |  |  |  |                                   |
|--|--|--|---|--|--|--|---|--|--|--|--|-----------------------------------|
| Physician /Medical Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ineta V. Whyte</b>  |  |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>4 22 2012</b>         | 3. Time of Death<br><b>8:19 a M</b>  |  |  |                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>550 Village Ct</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Salisbury</b>   |  |  | 4c. County of Death<br><b>Wicomico</b>                |  |  |  |  |                                   |
| Funeral Director   | 5. Social Security Number<br><b>129-72-2135</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b><br>Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>7-31-1936</b> | 9. Birthplace (State or Foreign Country)<br><b>WI</b> |  |  |  |  |                                   |
|  | Usual Residence of Decedent<br>10a. State<br><b>MD</b>   |  |   | 10b. County<br><b>Wicomico</b>   |  |  | 10c. City, Town or Location<br><b>Salisbury</b>       |  |  |  |  |                                   |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>550 Village Ct</b>  |  |   | 10f. Zip Code<br><b>21801</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>           |  |  |  |  |                                   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>Year or Dates:</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>Black</b> |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> |  |  |  |                                   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>None</b>        |  |  | 16b. Kind of Business/Industry<br><b>None</b>         |  |  |  |  |                                   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Theodore Charles</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Miarim Andrews</b>   |  |   |  |  |  |  |                                   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith Hoyle/Daughter</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11570 Old School Rd, Mardela Springs, MD 21837</b> |  |  |   |  |  |  |  |                                   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Rosedale Cem</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rosedale Cem</b>   |  | Date<br><b>4-28-2012</b>   | 20c. Location - City or Town, State<br><b>Linden, NJ</b>   |   |  |  |  |  |                                   |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>PO Box 326</b>   |  | McPherson Fun Ser Milford, DE 19963  |  |   |  |  |  |  |                                   |
| Physician /Medical Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>METASTATIC CANCER</b>   |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>4 WEEKS</b>   |  |  |                                   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Due to (or as a consequence of):<br><b>ASCO</b>   |  |   |  |  |  |   |  | 5 YEARS  |  |  |                                   |
|  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |  |   |  |  |  |  |                                   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  | 23d. Date of delivery<br>Month Day Year                    |   |  |  |  |  |                                   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |                                   |
|  | 23f. Did alcohol contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  |   |  |  |  |   |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |                                   |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  | 29b. Signature and title of certifier<br>   |  |  |                                   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. USHA NATESAN 1415 S. DIVISION ST, SALISBURY, MD 21804</b>   |  |   |  |  |  |   |  | 29c. License number<br><b>DOS1359</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 25 2012</b>                      |                                   |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 26 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |  |                                   |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend Items 25, 27, 28a-f per me, 927.05/11/2012dhp Certificate of Death

Reg. No.

2012 15472

|   |   |   |   |   |   |  |  |  |
|---|---|---|---|---|---|--|--|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 1. Decedent's Name (First, Middle, Last)<br><i>Priscilla C Williams</i>   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>2</b> Year <b>2012</b>  | 3. Time of Death<br><b>8:00 A M</b>                              |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>802 SALISBURY WAY</b>  |   | 4b. City, Town, or Location of Death<br><b>STEVENSVILLE</b>   |   | 4c. County of Death<br><b>QUEEN ANNE'S</b>  |  |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>001-09-4298</b>   | 6. Sex<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>96</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>08/07/1915</b>      | 9. Birthplace (State or Foreign Country)<br><b>NEW HAMPSHIRE</b>   |  |
| <b>To Be Completed by Funeral Director</b>                                | 10a. State<br><b>MD</b>   | 10b. County<br><b>QUEEN ANNE'S</b>  | 10c. City, Town or Location<br><b>STEVENSVILLE</b>  |   |   |  | 10d. Inside City Limits<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>802 SALISBURY WAY</b>  |   |   | 10f. Zip Code<br><b>21666</b>   |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>            |  |  |
|   | 11. Marital Status<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:<br><b>WHITE</b> |   | 14. Race - American Indian, Black, White, etc.                   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CATERER</b>   |   | 16b. Kind of Business/Industry<br><b>FOOD SERVICE</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ALFRED HOULE</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GLADYS TRAFTON</b>  |   |  |  |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>LEE WILLIAMS / DAUGHTER</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>802 SALISBURY WAY, STEVENSVILLE, MD 21666</b>   |   |   |  |  |  |
|   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NEW COLD SPRING CEMETERY</b>   |   | Date<br><b>05/12/2012</b>   | 20c. Location - City or Town, State<br><b>EAST ROCHESTER, NH</b> |  |  |
| <b>Medical Certificate: To Be Completed by Physician/Medical Examiner</b> | 21. Signature of Funeral Service Licensee<br><i>Clay M. Hough</i>   |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, P.A.<br/>106 SHAMROCK ROAD, CHESTER, MD 21619</b>   |   |   |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive Heart Failure</b><br>Approximate Interval Between Onset and Death<br><b>1 year</b>  |   |   |   |   |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><i>J. Hough, M.D., D.E.A.B.P.M.</i>   |   |   |   |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br><b>9</b> <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><b>1</b> <input type="checkbox"/> Live Birth <b>2</b> <input type="checkbox"/> Fetal death <b>3</b> <input type="checkbox"/> Ectopic pregnancy<br><b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (Specify)<br><b>9</b> <input type="checkbox"/> Unknown |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fractures - thoracic vertebrae, pubic rami<br/>Atrial fibrillation<br/>Hyperension</b>   |   |   |   |   |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown  |   |   |   |   |  |  |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |   |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><b>1</b> <input checked="" type="checkbox"/> Yes <i>X</i>   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
|   | 27. Manner of Death<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input checked="" type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)<br><b>04/13/2012</b>   | 28b. Time of injury<br><b>Unknown</b>   | 28c. Injury at work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred<br><b>Fall from standing</b>   |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |   |   |   |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>802 Salisbury Way, Stevensville, MD</b>  |   |   |   |   |  |  |  |
|   | 29a. Certifier<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3</b> <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br><b>D41586</b>  |   |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Sharon M. Messier/MD</i>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/2/12</b>  |   |   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sharon M. Messier/MD, 821 W Benfield Rd, Suite 8, Severna Park, MD 21146</b>   |   |   |   |   |  |  |  |
| <b>State<br/>Registrar</b>  | 31. Date filed (Month, Day, Year)<br><b>MAY 11 2012</b>   |   | 32. Registrar's Signature<br><i>James A. Farrel</i>   |   |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

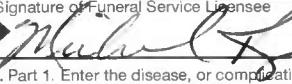
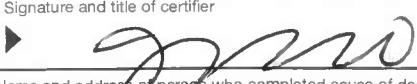
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15473

1 - For  
State  
Registrar

|  |   |                                  |   |  |   |  |  |  |  |
|--|---|----------------------------------|---|--|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>ANGELA ANDERSON WILLIAMS</b>   |                                  |   |  |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>5</b> Year <b>2012</b>   | 3. Time of Death<br>3:20P M  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>29480 HORSE RANGE FARM LANE</b>  |                                  |   | 4b. City, Town, or Location of Death<br><b>MECHANICSVILLE</b>  |   |  | 4c. County of Death<br><b>ST. MARY'S</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-92-8572</b>   |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> X  | 7. Age (In yrs. last birthday)<br><b>50 Yrs.</b>   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>1-4-1962</b>  | 9. Birthplace (State or Foreign Country)<br><b>WASH., D.C.</b>         |  |
|  | Usual Residence of Decedent   |                                  |   |  | Hours   | Min.   |  |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD.</b>  | 10b. County<br><b>ST. MARY'S</b> | 10c. City, Town or Location<br><b>MECHANICSVILLE</b>  |  |   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>29480 HORSE RANGE FARM LANE</b>  |                                  |   | 10f. Zip Code<br><b>20659</b>  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>WHITE</b> |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |                                  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                             |   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HARRY L ANDERSON</b>  |                                  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BARBARA TEMPLE SLAID</b>  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES W. WILLIAMS-SPOUSE</b>   |                                  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29480 HORSE RANGE FARM LA. MECHANICSVILLE, MD. 20659</b> |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>TRINITY MEM GARDENS</b>  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEM GARDENS</b>  |  |   | Date<br><b>5-9-12</b>  | 20c. Location - City or Town, State<br><b>WALDORF, MD. 20659</b>   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |                                  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.<br/>LA PLATA, MARYLAND 20646</b>   |  |   |  |  |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b>  |                                  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |
|  | <p>a. Due to (or as a consequence of):<br/><b>Lung Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>   |                                  |   |  |   |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |                                  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |   | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |                                  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |                                  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)       |  |   |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |                                  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |  |
|  |   |                                  |   |  |   |  |  |  |  |
|  |   |                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                  |   |  |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br>  |                                  | 29c. License number<br><b>MO055751</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-8-2012</b>                           |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Schmidt DO 40900 Merchants Lane Leonardtown MD 20650</b>  |                                  |   |  |   |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 15 2012</b>   |                                  | 32. Registrar/Signatur<br>   |  |   |  |  |  |  |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

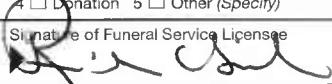
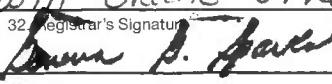
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15474

1- For State Registrar

|                                     |  |   |                           |  |  |  |  |   |   |   |  |                                 |   |                                   |
|-------------------------------------|--|---|---------------------------|--|--|--|--|---|---|---|--|---------------------------------|---|-----------------------------------|
| Physician/<br>Medical<br>Examiner   |  | 1. Decedent's Name (First, Middle, Last)<br><b>PAULINE, ACTON</b>   |                           |  |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>10</b> Year <b>2012</b>   |   | 3. Time of Death<br><b>n/a</b>  |  |                                 |   |                                   |
| Funeral Director                    |  | 4a. Facility Name (if not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND Medical CENTER</b>  |                           |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |  | 4c. County of Death<br><b>n/a</b>   |   |   |  |                                 |   |                                   |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br><b>215-76-2960</b>   |                           | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (in yrs. last birthday)<br><b>76</b><br>Yrs.  | If Under 1 Year<br>Months<br><b> </b>  | If Under 24 Hrs.<br>Days<br><b> </b>   | 8. Date of Birth<br>(Month, Day, Year)<br><b>7/24/1935</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |   |  |                                 |   |                                   |
|                                     |  | 10a. State<br><b>MD</b>   | 10b. County<br><b>n/a</b> | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |  |   |   | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |                                 |   |                                   |
|                                     |  | 10e. Street and Number<br><b>818 Washington Blvd.</b>   |                           |  |  | 10f. Zip Code<br><b>21230</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |                                 |   |                                   |
|                                     |  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br/>If Yes, Give Year or Dates.</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  |   | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |   |  |                                 |   |                                   |
|                                     |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>  |                           |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |   |  |                                 |   |                                   |
|                                     |  | 17. Father's Name (First, Middle, Last)<br><b>Paul R. Herd, Sr.</b>   |                           |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary A. Upton</b>  |  |   |   |   |  |                                 |   |                                   |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Debra L. Johnson/ Daughter</b>   |                           |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9218A Avondale Road, Baltimore, Maryland 21234</b>   |  |   |   |   |  |                                 |   |                                   |
|                                     |  | 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  |  | Date<br><b>5/14/2012</b>   | 20c. Location - City or Town, State<br><b>Brooklyn Park, MD</b>   |   |   |  |                                 |   |                                   |
|                                     |  | 21. Signature of Funeral Service Licensee<br>  |                           |  |  | 22. Name and Address of Facility<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Avenue, Baltimore, Maryland 21229</b>   |  |   |   |   |  |                                 |   |                                   |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                           |  |  |  |  | Approximate Interval Between Onset and Death  |   |   |  |                                 |   |                                   |
|                                     |  | <p>a. <b>PNEUMONIC</b><br/>Due to (or as a consequence of):</p> <p>b. <b>COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE)</b><br/>Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>  |                           |  |  |  |  |   |   |   |  |                                 |   |                                   |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |                           | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br/>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br/>9 <input type="checkbox"/> Unknown</b> |  |  | 23d. Date of delivery<br>Month Day Year  |   |   |   |  |                                 |   |                                   |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>   |                           |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b> |   |   |  |                                 |   |                                   |
|                                     |  |   |                           |  |  |  |  | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |                                 |   |                                   |
|                                     |  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |                           | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>  |  |  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> |   |   | 28a. Date of injury (Month, Day, Year)<br><b> </b>  |  | 28b. Time of injury<br><b>M</b> | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred |
|                                     |  |   |                           |  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b> </b>  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b> </b>   |                                 |   |                                   |
|                                     |  | 29a. Certifier<br>(Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br/>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                           | 29c. License number<br><b>DC09550</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5-10-12</b>  |   |   |   |  |                                 |   |                                   |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KIM BIZZELL 22 SOUTH GREENE STREET N10W BALTIMORE MD 21201</b>   |                           |  |  |  |  |   |   |   |  |                                 |   |                                   |
| State Registrar                     |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |                           | 32. Registrar's Signature<br>   |  |  |  |   |   |   |  |                                 |   |                                   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15475

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |   |
|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  | 3. Time of Death<br>Hour Minute AM/PM               |
| <b>STEPHEN ALAN Allison</b>   |  | May 12 2012   | 9:51 AM   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Medstar Harbor Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   |
| 5. Social Security Number<br><b>216-60-9861</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b><br>Yrs. |
| 8. Date of Birth<br>(Month Day Year)<br><b>05/26/1953</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |   |
| 10c. City, Town or Location<br><b>Pasadena</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>7612 Bens Way</b>  |  | 10f. Zip Code<br><b>21122</b>   |   |
| 10g. Citizen of What Country?<br><b>USA</b>   |  |   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>Plumber</b>   |   |
| 16b. Kind of Business/Industry<br><b>Service</b>  |  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Herbert Allison</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah</b>   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Beth Allison / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7612 Bens Way, Pasadena, MD 21122</b>   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Chesapeake Crematory</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   | Date<br><b>5/14/2012</b>                            |
| 21. Signature of Funeral Service Licensee<br><b>Dorota Marshall</b>   |  | 22. Name and Address of Facility<br><b>Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203</b>   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death<br><b>1 year</b>   |   |
| a. <i>Squamous cell carcinoma of larynx</i><br>Due to (or as a consequence of):   |  |   |   |
| b. _____<br>Due to (or as a consequence of):  |  |   |   |
| c. _____<br>Due to (or as a consequence of):  |  |   |   |
| d. _____  |  |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia of chronic disease</b><br><b>malnutrition</b><br><b>hyperlipidemia</b>  |  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)               |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)<br><b>May</b>   |   |
| 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>At home</b>  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, MD 21203</b>  |  |   |   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>RES-001</b>   |   |
| 29d. Date signed (Month, Day, Year)<br><b>May 12 2012</b>   |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jinchira Bisson 3001 S. Hanover Street Baltimore 21225</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |   |
| 32. Registrar's Signature<br><b>Jinchira Bisson</b>   |  |   |   |

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15476

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|   |  |  |  |  |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ANITA L ABRAMS</b>   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>13</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>06:06P M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>GILCHRIST HOSPICE CARE</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>217-22-9254</b>   |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>92 Yrs.</b> | If Under 1 Year<br>Months <b> </b> Days <b> </b> If Under 24 Hrs.<br>Hours <b> </b> Min. <b> </b>  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>06/04/1919</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  | 10. Usual Residence of Decedent<br><b>MD BALTIMORE</b>   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>PIKESVILLE</b>   |
| 10e. Street and Number<br><b>725 MT WILSON LANE, #325</b>   |  | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><b>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.<br><b> </b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b>WHITE</b> |
| 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT H LEVY</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LENA SIEGEL</b>  |  | 16b. Kind of Business/Industry<br><b>ACCOUNTING</b>  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JACQUES ABRAMS / SON</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>148 LINDEN STREET, #6, WELLESLEY, MA 02482</b>   |  |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>  |  | Date<br><b>05/15/2012</b>  |
| 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Michael Bruger</b>   |  |  |
| 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular Accident</b>   |  |  |
| 23a. Due to (or as a consequence of):<br><b> </b>   |  | Approximate Interval Between Onset and Death<br><b> </b>   |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Atrial Fibrillation</b>   |  | 23c. Due to (or as a consequence of):<br><b> </b>  |  |  |
| 23d. Date of delivery<br>Month <b> </b> Day <b> </b> Year <b> </b>  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>  |  |  |
| 23f. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  | 23g. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  |  |
| 23h. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  | 23i. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>  |  |  |
| 24. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 25. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b>  |  | 27. Other:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br><b>Hospice</b>   |  |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  | 28a. Date of injury (Month, Day, Year)<br><b> </b>   |  |  |
| 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |  |
| 28d. Describe how injury occurred<br><b> </b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b> </b>   |  |  |
| 29b. Signature and title of certifier<br><b>M.D.</b>  |  | 29c. License number<br><b>D0071287</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip Shahney, 6701 N. Charles St. #4105, Baltimore, MD, 21204</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5-14-12</b>  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |  | 32. Registrar's Signature<br><b> </b>  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15477

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |                           |   |  |  |
|--|---------------------------|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Norman D. Boies</b>   |                           | 2. Date of Death<br>Month <b>4</b> Day <b>30</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>4:16 a M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>   |                           | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>214-38-7559</b>  |                           | 6. Sex<br><b>1 X M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | If Under 1 Year<br>Months      Days      Hours      Min.                             |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>3/3/42</b>  |                           | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |
| 10e. Street and Number<br><b>1439 Andre Street</b>   |                           | 10f. Zip Code<br><b>21230</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>Army</b>  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b></b> |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |                           | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>President Boies Enterprises</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>                                |
| 17. Father's Name (First, Middle, Last)<br><b>Norman Boies</b>   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thelma Helms</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Annette Boies / Wife</b>  |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1439 Andre Street Baltimore Maryland 21230</b>  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Victor P. Doda</b>   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ardent Crematory</b>   | Date<br><b>5/7/2012</b>  | 20c. Location - City or Town, State<br><b>Hanover Maryland</b>                       |
| 21. Signature of Funeral Service Employee<br><b>Victor P. Doda</b>   |                           | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore MD 21230</b>  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                           | Approximate Interval Between Onset and Death<br><b>days</b>   |  |  |
| a. <b>Sepsis</b><br>Due to (or as a consequence of):   |                           |   |  |  |
| b. <b>bowel obstruction and perforation</b><br>Due to (or as a consequence of):  |                           | <b>days</b>   |  |  |
| c. <b>Clostridium difficile colitis</b><br>Due to (or as a consequence of):  |                           | <b>weeks</b>  |  |  |
| d. _____   |                           |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |                           | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown                   |  |  |
| 23d. Date of delivery<br>Month Day Year  |                           |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Lung cancer</b>   |                           | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br><b>Hospice</b> |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |                           | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29b. Signature and title of certifier<br><b>► Debrah Boies</b>   |                           | 29c. License number<br><b>DS8303</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 30 2012</b>                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Aaron J Charles 6701 N. Charles St. Baltimore MD</b>  |                           |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |                           | 32. Registrar's Signature<br><b>Debrah Boies</b>  |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15478

For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 2f is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |
|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month 05 Day 15 Year 2012   |  | 3. Time of Death<br>1:30 AM M   |
| Emma Frances Bright  |  |   |  |   |
| 4a. Facility Name (if not institution, give street and number)   |  | 4b. City, Town, or Location of Death  |  | 4c. County of Death   |
| Upper Chesapeake Medical Center  |  | Bel Air   |  | Harford   |
| 5. Social Security Number<br><b>215-09-3183</b><br>Usual Residence of Decedent   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>94 Yrs.  | If Under 1 Year<br>Months Days Hours Min.<br>8. Date of Birth<br>(Month, Day, Year)<br><b>08/02/1917</b>  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baldwin</b>   |
| 10e. Street and Number<br><b>6708 Cherry Hill Road</b>   |  | 10f. Zip Code<br><b>21013</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                 |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>9</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Wilhemia Sandman</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Martin L. Bright (son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6708 Cherry Hill Road - Baldwin, Maryland 21013</b>   |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | Date<br><b>05/18/2012</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home, P.A.</b><br><b>11750 Belair Road - Kingsville, Maryland 21087</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |
| a. Due to (or as a consequence of):<br><b>ACUTE MYOCARDIAL INFARCTION.</b>   |  |   |  |   |
| b. Due to (or as a consequence of):  |  |   |  |   |
| c. Due to (or as a consequence of):  |  |   |  |   |
| d. _____   |  |   |  |   |
| Approximate Interval Between Onset and Death   |  |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMER DEMENTIA.</b>   |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)         |  | 23f. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |  | 28d. Describe how injury occurred   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>ATTENDING PHYSICIAN</b>   |  |   |
| 29c. License number<br><b>000 62239</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 15 2012</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>UPPER CHESAPEAKE MEDICAL CENTER, BELAIR MD 21014.</b>   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |  | 32. Registrar's Signature<br>  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend Item 25 per me, g928, 06/11/2012dhb Certificate of Death Reg. No. 2012 15479  
Registrar

|  |   |   |   |   |   |  |  |   |
|--|---|---|---|---|---|--|--|---|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles E. Bouknight, Jr.</b>  |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>05</b> Year <b>2012</b>                         | 3. Time of Death<br><b>14:28 PM</b>  |  |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>  |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death<br><b>N/A</b>   |  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-82-2290</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>46</b><br>Yrs.   | If Under 1 Year<br>Months    Days    Hours    Min.                              | 8. Date of Birth<br>(Month Day Year)<br><b>Jun 25, 1965</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>SC</b>  |  |   |
| To Be Completed by Funeral Director                                | Usual Residence of Decedent<br><b>MD Baltimore City</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> 2 <input type="checkbox"/> No  |  |   |
|  | 10e. Street and Number<br><b>7110 Minna Road</b>  |   |   | 10f. Zip Code<br><b>21217</b>   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>X</b> | 14. Race - American Indian, Black, White, etc.<br><b>Black</b><br>Specify:      |   |  |  |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Social Worker</b>                    | 16b. Kind of Business/Industry<br><b>Dept. of Social Services</b>               |   |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Bouknight Jr</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie M. Bouknight</b> |   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillie Brown</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7110 Minna Road Baltimore, MD 21217</b>             |   |   |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  | Date<br><b>May 16, 2012</b>   | 20c. Location - City or Town, State<br><b>Lansdowne, Maryland</b>                           |  |  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Howard M. Estep</b>   |   | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P. A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>                               |   |   |  |  |   |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acute Intracerebral Hemorrhage</b>   |   |   |   |   | Approximate Interval Between Onset and Death<br><b>approximately 1 day</b>   |  |   |
|  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |   |   |  |  |   |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |   |   |   |   | 23d. Date of delivery<br>Month Day Year  |  |   |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus type 2, Hypertension, Anemia of Chronic disease, cardiac arrest (02/13/12), Deep vein thrombosis, Lupus</b>  |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |  |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
|  | 29a. Certifier<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> only one<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   | 29b. Signature and title of certifier<br><b>Howard M. Estep</b>  | 29c. License number<br><b>RES-000</b>              | 29d. Date signed (Month, Day, Year)<br><b>May, 05, 2012</b> |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TAMNA WANG JAM, Sinai Hospital Of Baltimore</b>  |   |   |   |   | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  | 32. Registrar's Signature<br><b>Leanne J. Park</b> |   |

Patient known as Bouknight, Charles  
Baltimore, Maryland 21215-0336

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Jay to me  
Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

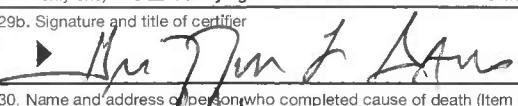
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2012 15480

1 - For  
State  
Registrar

**Physician/  
Medical  
Examiner**

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES WILLIAM BRISCOE, JR.</b>  |   |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>11</b> Year <b>2012</b>              | 3. Time of Death<br>2329 P M  |  |
|  |  | 4a. Facility Name (If not institution, give street and number)<br><b>PG HOSPITAL CENTER</b>  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |  | 4c. County of Death<br><b>PG</b>  |  |
|  |  | 5. Social Security Number<br><b>577-25-2740</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.   | If Under 1 Year<br>Months      Days   | If Under 24 Hrs.<br>Hours      Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>JUNE 14, 1958</b>  | 9. Birthplace (State or Foreign Country)<br><b>DC</b>  |
|  |  | Usual Residence of Decedent<br><b>MD PG</b>  |   | 10a. State      10b. County<br><b>SEAT PLEASANT</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | 10e. Street and Number<br><b>706 65TH AVE</b>  |   |  | 10f. Zip Code<br><b>20743</b>   |  | 10g. Citizen of What Country?<br><b>US</b>  |  |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>11TH</b>   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CAR SALESMAN</b>  |  |   | 16b. Kind of Business/Industry<br><b>PRIVATE</b>   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>JAMES WILLIAM BRISCOE</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AGNES LOUISE TURNER</b>  |   |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>IONE BRISCOE/WIFE</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1113 ELFIN AVE, CAPITOL HEIGHTS, MD 20743</b>   |  |   |  |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. OLIVET CEMETERY</b>   |   | Date<br><b>MAY 19, 2012</b>  | 20c. Location - City or Town, State<br><b>WASHINGTON, DC</b>  |  |
|  |  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility <b>POPE FUNERAL HOMES, P.A.</b><br><b>5538 MARLBORO PIKE, FORESTVILLE, MD 20747</b>   |   |  |   |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |   | Approximate Interval Between Onset and Death   |   |  |   |  |
|  |  | <p>a. <b>FATAL CARDIAC ARRHYTHMIA</b><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____</p>   |   |  |   |  |   |  |
|  |  | Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |  |   |  |
|  |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown      |   |  | 23d. Date of delivery<br>Month      Day      Year   |  |
|  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |  |
|  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred   |  |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |
|  |  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |  |
|  |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>A0063688</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 15, 2012</b>                       |   |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GRIFFIN DAVIS 3001 HOSPITAL DR. CHEVERLY, MD 20785</b>  |   |  |   |  |   |  |
|  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |   | 32. Registrar's Signature<br>   |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15481

For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Otto

Beverly

2. Date of Death

Month  
MayDay  
12Year  
20123. Time of Death  
16 35 M

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Medical Certificate: To Be Completed by Physician/Medical Examiner

## To Be Completed by Funeral Director

|   |                          |   |   |   |  |
|---|--------------------------|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)  |                          |   | 2. Date of Death  |   |  |
| Otto Beverly  |                          |   | Month<br>May Day<br>12 Year<br>2012   |   |  |
| 4a. Facility Name (if not institution, give street and number)  |                          |   | 4b. City, Town, or Location of Death  |   |  |
| The Johns Hopkins Hospital  |                          |   | Baltimore City  |   |  |
| 5. Social Security Number   |                          | 6. Sex  | 7. Age (In yrs. last birthday)  | 8. Date of Birth  |  |
| 218-86-3966   |                          | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 47 Yrs.   | Month<br>Sept. Day<br>10, Year<br>1964  |  |
| Usual Residence of Decedent   |                          | If Under 1 Year<br>Months Days Hours Min.   |   | 9. Birthplace (State or Foreign Country)  |  |
| 10a. State<br>Md  | 10b. County<br>Baltimore | 10c. City, Town or Location<br>Parkville  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10e. Street and Number<br>2915 Putty Hill Ave.  |                          |   | 10f. Zip Code<br>21234  |   | 10g. Citizen of What Country?<br>USA                 |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |                          | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)                   |   | 16b. Kind of Business/Industry<br>Food Service Worker   |  |
| 17. Father's Name (First, Middle, Last)<br>Alvin Beverly  |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Salley  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Stacie Pugh/Sister  |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2915 Putty Hill Ave. Parkville, Md 21234 |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Crematory  |   | Date<br>May 23, 2012  | 20c. Location - City or Town, State<br>Baltimore, Md |
| 21. Signature of Funeral Service Licensee   |                          | 22. Name and Address of Facility<br>CALVIN B. SCRUGGS FUNERAL HOME<br>1412 E. PRESTON ST. BALTO. MD 21213   |   |   |  |

|  |  |  |  |
|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  |  | Approximate Interval Between Onset and Death |
| a. Ischemic Cardiomyopathy<br>Due to (or as a consequence of):   |  |  |  |
| b. _____<br>Due to (or as a consequence of):   |  |  |  |
| c. _____<br>Due to (or as a consequence of):   |  |  |  |
| d. _____   |  |  |  |

|   |   |   |
|---|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |

|  |   |                     |  |  |
|--|---|---------------------|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                     |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury | 28c. Injury at work?<br>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred  |
|  |   |                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
|  |   |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |

|  |                                |  |
|--|--------------------------------|--|
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29c. License number<br>RES-000 | 29d. Date signed (Month, Day, Year)<br>May 12 2012 |
|--|--------------------------------|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Isida Buki | 1800 Orleans St Baltimore Maryland 21287   |
| 31. Date filed (Month, Day, Year)<br>MAY 16 2012   | 32. Registrar's Signature<br>Anna J. Gales |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15482

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

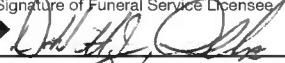
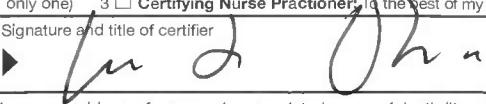
Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> Year <b>2012</b>   |  |  |  | 3. Time of Death<br><b>7:17 PM</b>   |  |
| Susan Ingels Block   |  |   |  |  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Laurel Regional Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |  |  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| 5. Social Security Number<br><b>214-54-9618</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Apr 26, 1952</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>    |
| Usual Residence of Decedent  |  | 10a. State<br><b>MD</b> 10b. County<br><b>Prince George</b> 10c. City, Town or Location<br><b>Laurel</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>12127 Dove Circle</b>   |  | 10f. Zip Code<br><b>20708</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) <b>2</b><br>Homemaker   |  | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Jackson Ingels</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marion Eva Bruckner</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert A. Block /spouse</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12127 Dove Circle, Laurel, Maryland 20708</b>   |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>W. Arundel Crematory</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>W. Arundel Crematory</b>   |  | Date<br><b>May 12, 2012</b>  | 20c. Location - City or Town, State<br><b>Odenton, Maryland</b>                  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.</b><br><b>313 Talbott Ave., Laurel, Maryland 20707-4389</b>   |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |  | 23b. Due to (or as a consequence of):<br><b>Hepatic Encephalopathy</b>  |  |  |  | Approximate Interval Between Onset and Death   |  |
| {<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23c. Due to (or as a consequence of):<br><b>Non ST Elevation MI</b>   |  |  |  |  |  |
| {<br>d. Due to (or as a consequence of):<br><b>Severe Sepsis</b>   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____<br><input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                 |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D41248</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 11, 2012</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George I. Okang, MD</b> <b>Laurel Regional Hospital</b>   |  |   |  |  |  | <b>7300 Van Dusen Road</b><br><b>Laurel, MD 20707</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15483

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month Day Year   |  |   |  | 3. Time of Death<br>6:49 PM  |  |
| <b>HENRY JAMES BRIDGE</b>  |  | May 14 2012  |  |   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>217-46-4429</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  |  | If Under 1 Year<br>Months Days Hours Min.  |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>8-31-43</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>ARRIBUTUS</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 10e. Street and Number<br><b>1926 BRADY AVE.</b>   |  | 10f. Zip Code<br><b>21227</b>  |  |   |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>CLAIMS EXAMINER</b>   |  | 16b. Kind of Business/Industry<br><b>SOCIAL SECURITY ADMINISTRATION</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES BRIDGE</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LOUISE BIBRELE</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES P. DOWNEY, NEPHEW</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6423 GOLDEN OAK DR. LINTHICUM, MD. 21090</b>   |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>JAMES P. DOWNEY 6423 GOLDEN OAK DR. LINTHICUM, MD. 21090</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>W. AROUND CEMETERY 5-15-12</b>  |  | Date  |  | 20c. Location - City or Town, State<br><b>Odenton, MD</b>                                      |  |
| 21. Signature of Funeral Service Licensee<br><b>JAMES P. DOWNEY 6423 GOLDEN OAK DR. LINTHICUM, MD. 21090</b>   |  | 22. Name and Address of Facility<br><b>DAUGHERTY FUNERAL HOME<br/>12601 MOUNTAIN RD. PASADENA, MD. 21122</b>   |  |   |  |  |  |
| 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)                              |  |   |  | Approximate Interval Between Onset and Death<br><b>4 days</b>                                  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury<br>(Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>► Ashima M.D.</b>  |  |   |  | 29c. License number<br><b>P25484</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Srivastava, Ashima</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |  |   |  | 32. Registrar's Signature<br><b>Jeanne P. Faust</b>  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012

15484

1- For  
State  
Registrar

|  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Margaret Beaumont</b>  |  |  |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>May 12, 2012</b>                                      | 3. Time of Death<br><b>5:50 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5605 Huntsmoor Road</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |  |  | 4c. County of Death<br><b>Baltimore</b>                           |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-40-8049</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69 Yrs.</b>         | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month Day Year)<br><b>6/22/42</b>            | 9. Birthplace (State or Foreign<br>Country)<br><b>Maryland</b>                                 |  |  |
|  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>5605 Huntsmoor Road</b>   |  |  | 10f. Zip Code<br><b>21227</b>                            |  |  | 10g. Citizen of What Country?<br><b>USA</b>                       |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>1960</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                     |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Worker</b>   |  | 16b. Kind of Business/Industry<br><b>Black &amp; Decker</b>  |  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edwin C. Corbin</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Movina M. McClellan</b>  |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Andrew J. Neff / Companion</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5605 Huntsmoor Rd. Baltimore, Maryland 21227</b>   |  |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)<br><b>Entombment</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |  |  | Date<br><b>5/15/12</b>   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Edgar J. Neff</b>  |  | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home<br/>3620 Wilkens Ave. Baltimore, Maryland 21229</b>  |  |  |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Emphysema</b>   |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension<br/>Hyperlipidemia</b>  |  |  |  |  |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of Injury<br>M                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29c. License number<br><b>D 21649</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>  |   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAMBANDAM BASKARAN 3455 Wilkens Ave, Baltimore, MD 21229</b>  |  | 32. Registrar's Signature<br><b>Levina J. Sarkeran</b>   |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15485

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|   |                                 |   |  |   |
|---|---------------------------------|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Thomas Barry</b>  |                                 |   | 2. Date of Death<br>Month <b>May</b> Day <b>11</b> Year <b>2012</b>  | 3. Time of Death<br><b>10:45 PM</b>                         |
| 4a. Facility Name (if not institution, give street and number)<br><b>620 Straffan Drive #301</b>  |                                 |   | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |   |
| 5. Social Security Number<br><b>219-22-8297</b>   |                                 |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>83 Yrs.</b>            |
| 8. Usual Residence of Decedent<br><b>Baltimore</b>  |                                 |   | If Under 1 Year<br>Months      Days  | If Under 24 Hrs.<br>Hours      Min.                         |
| 10a. State<br><b>MD.</b>  | 10b. County<br><b>Baltimore</b> | 10c. City, Town or Location<br><b>Timonium</b>  |  |   |
| 10e. Street and Number<br><b>620 Straffan Drive #301</b>  |                                 |   | 10f. Zip Code<br><b>21093</b>  |   |
| 10g. Citizen of What Country?<br><b>USA</b>   |                                 |   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:<br><b>White</b> |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |                                 | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>                   |  | 16b. Kind of Business/Industry<br><b>Exxon</b>              |
| 17. Father's Name (First, Middle, Last)<br><b>Robert W. Barry</b>   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Helfrich</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anne Dowers/ Daughter</b>  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Shady Brook Ln. Cranbury, NJ. 08512</b>    |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem.</b>  | Date<br><b>5-17-12</b>   | 20c. Location - City or Town, State<br><b>Timonium, MD.</b> |
| 21. Signature of Funeral Service Licensee<br>  |                                 | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, md. 21204</b>                                     |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |                          |  |
|---|--|--|--------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Due to (or as a consequence of):<br><b>adenocarcinoma, lung</b>   |                          | Approximate Interval Between Onset and Death<br><b>2 years</b>                   |
| 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Undulating Cause (Disease or injury that initiated events resulting in death) Last   |  | 23d. Date of delivery<br>Month      Day      Year  |                          |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |                          |  |
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                          | 28d. Describe how injury occurred  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><br><b>Lawrence J. Snyder MD</b>   |                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7600 Osler Drive, Suite 411, Towson, MD 21204</b>  |  | 29c. License number<br><b>D 00 30122</b>   |                          |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/14/2012</b>  |                          |  |
| 32. Registrar's Signature<br>  |  |  |                          |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend #18 Per FH G927 5/16/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15486

1 - For  
State  
Registrar

|  |   |  |   |   |   |  |   |  |         |
|--|---|--|---|---|---|--|---|--|---------|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)  |  |   |   | 2. Date of Death<br>Month<br>05   | Day<br>14  | Year<br>2012  | 3. Time of Death<br>11:12 PM <sup>M</sup>  |         |
|  | James Sloan Calwell, III  |  |   |   | Belcamp   |  |   |  | Harford |
| Funeral<br>Director  | 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death      |   |   | 4c. County of Death  |   |  |         |
|  | Lorien Riverside  |  | Belcamp                                   |   |   | Harford  |   |  |         |
| To Be Completed by Funeral Director  | 5. Social Security Number<br>212-20-5564  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>86 Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth<br>(Month, Day, Year)<br>07/16/1925   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |         |
|  | Usual Residence of Decedent<br>MD Baltimore   |  | Perry Hall                                |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |         |
| 10a. State<br>MD   |   | 10b. County<br>Baltimore   |   | 10c. City, Town or Location<br>Perry Hall   |   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |         |
| 10e. Street and Number<br>4501-L Talcott Terrace   |   |  |   |   | 10f. Zip Code<br>21128  |  |   |  |         |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. WW II  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |         |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>3   |   | 16b. Kind of Business/Industry<br>Engineer  |   |  | Western Electric Co.  |  |         |
| 17. Father's Name (First, Middle, Last)<br>James S. Calwell, II  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence Scott Wendel  |   |  |   |  |         |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marie E. Calwell (wife)  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4501-L Talcott Terrace - Perry Hall, Maryland 21128   |   |   | Date  |  |   | 20c. Location - City or Town, State<br>Owings Mills, Maryland  |         |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br>► E. F. Lassahn   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Cem.   |   |   | 20c. Location - City or Town, State<br>Owings Mills, Maryland   |  |   | 05/18/2012   |         |
| 21. Signature of Funeral Service Licensee  |   | 22. Name and Address of Facility<br>E. F. Lassahn Funeral Home, P.A.<br>11750 Belair Road - Kingsville, Maryland 21087   |   |   |   |  |   |  |         |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Esophageal CANCER |  |   |   |   |  |   | Approximate Interval Between Onset and Death   |         |
|  | a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. _____   |  |   |   |   |  |   |  |         |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown    |   |   |   |  | 23d. Date of delivery<br>Month Day Year   |  |         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>hypertension, Dementia, Atrial fibrillation  |   |  |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |         |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |         |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury<br>(Month, Day, Year)  |   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      | 28d. Describe how injury occurred  |   |  |         |
| 5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |         |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |   |  |         |
| 29b. Signature and title of certifier<br>► Dr. W. McIlvane M.D.  |   | 29c. License number<br>D27975  |   |   | 29d. Date signed (Month, Day, Year)<br>5/15/12  |  |   |  |         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DAVID McILVANE M.D. 610 MARSHALL ST BEL AIR, MD 21014  |   |  |   |   |   |  |   |  |         |
| 31. Date filed (Month, Day, Year)<br>MAY 16 2012   |   | 32. Registrar's Signature<br>► Dr. David McIlvane  |   |   |   |  |   |  |         |

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8x1  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15487

1- For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month<br>May Day<br>8 Year<br>2012<br>4:00 P M  |  | 3. Time of Death   |
| Phyllis Shirley Channels  |  | Henderson   |  | Caroline   |
| 4a. Facility Name (if not institution, give street and number)<br><b>16840 Henderson Road; Lot 53</b>   |  | 4b. City, Town, or Location of Death<br><b>Henderson</b>  |  | 4c. County of Death<br><b>Caroline</b>   |
| 5. Social Security Number<br><b>219-26-6809</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b><br>Yrs.                                    | If Under 1 Year<br>Months Days Hours Min.<br>Feb. 16, 1939   |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 16, 1939</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| Usual Residence of Decedent<br><b>Maryland Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Glen Burnie</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>7466 Furnace Branch Road; Apt 207</b>  |  | 10f. Zip Code<br><b>21060</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><b>White</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Line Worker</b>   |  | 16b. Kind of Business Industry<br><b>Calvert Distillery</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilson Louis Elliott</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen May Wilson</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Douglas Channels/ son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16840 Henderson Road; Lot 53; Henderson, MD 21640</b>   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>Perry Aldridge</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory, Inc</b>   |  | 20c. Location - City or Town, State<br><b>2012 Baltimore, Maryland</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Perry Aldridge</b>  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Service P.A., 4001 Ritchie Highway Baltimore, Maryland 21225</b>   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive Heart Failure</b>   |  |   |  | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter U if there is no cause (Disease or injury that initiated events resulting in death) Last  |  | a. Due to (or as a consequence of):<br><b>Congestive Heart Failure</b>  |  |  |
|   |  | b. Due to (or as a consequence of):   |  |  |
|   |  | c. Due to (or as a consequence of):   |  |  |
|   |  | d. Due to (or as a consequence of):   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)                            |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                 |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)<br><b>Son's Home</b> |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   |  | 28d. Describe how injury occurred   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |
| 29a. Certifier<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one)<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br><b>063747</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/12</b>   |
| 29b. Signature and title of certifier<br><b>Jeffrey L. Vigan</b>  |  | 29c. License number<br><b>063747</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/9/12</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEFFREY L. VIGAN</b>   |  | 32. Registrar's Signature<br><b>Jeffrey L. Vigan</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |
| 32. Registrar's Signature<br><b>Jeffrey L. Vigan</b>  |  |   |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15488

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

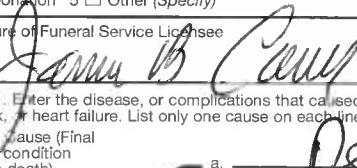
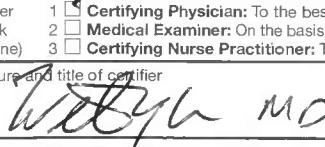
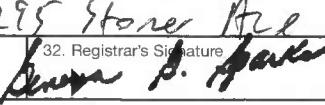
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |   |  |   |  |                                   |
|---|---|--|---|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Melvin Carman</b>   |   | 2. Date of Death<br>Month <b>May</b> Day <b>13</b> Year <b>2012</b>  | 3. Time of Death<br><b>12:57 PM</b>   |  |                                   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Transitions Health Care</b>  |   | 4b. City, Town, or Location of Death<br><b>Sylesville</b>  |   |  |                                   |
| 4c. County of Death<br><b>Carroll</b>   |   |  |   |  |                                   |
| 5. Social Security Number<br><b>216-16-5627</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b><br>Yrs.  | If Under 1 Year<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |                                   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Carroll</b>   | 10c. City, Town or Location<br><b>Eldersburg</b>   |   |  |                                   |
| 10e. Street and Number<br><b>1003 Johnsville Rd.</b>  |   | 10f. Zip Code<br><b>21784</b>  | 10g. Citizen of What Country?<br><b>USA</b>   |  |                                   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1942</b> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify.  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |                                   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>                               | 16b. Kind of Business/Industry<br><b>Caton Distributing Co.</b>  |   |  |                                   |
| 17. Father's Name (First, Middle, Last)<br><b>William Howell Carman</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Ruth Freedenburg</b>  |   |  |                                   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy Hull/Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1935 Gardenia St., Eldersburg, MD 21784</b>  |   |  |                                   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   | Date<br><b>5/17/2012</b>  |  |                                   |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Home &amp; Crematory, P.A.<br/>1212 W. Old Liberty Rd., Winfield, MD 21784</b>  |   |  |                                   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>   |   |  |   |  |                                   |
| Approximate Interval Between Onset and Death<br><b>Years</b>  |   |  |   |  |                                   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |   |  |                                   |
| 23b. If female:<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |  |   |  |                                   |
| 23d. Date of delivery<br>Month Day Year   |   |  |   |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |                                   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |                                   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                   |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |                                   |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>DO0058137</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/14/12</b>                                |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wilbur Kuo 295 Stone Ave ST 307 Westminster MD 21157</b>   |   |  |   |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |   | 32. Registrar's Signature<br>   |   |  |                                   |

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 15489

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner****Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.  
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |  | 3. Time of Death<br>1140 hrs   |
| <i>Richard Dean Coffman</i>   |  | May 7, 2012   |  |  |
| 4a. Facility Name (if not institution, give street and number)<br>656 Kittendale Circle   |  | 4b. City, Town, or Location of Death<br>Middle River  |  | 4c. County of Death<br>Baltimore County  |
| 5. Social Security Number<br><i>216-66-3214</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>56</i> Yrs.   | 8. If Under 1 Year<br>Months Days Hours Min.<br>9. Date of Birth (MM/DD/YYYY)<br><i>3/18/1956</i><br>9. Birthplace (State or Foreign Country)<br><i>MD</i> |
| 10a. State<br><i>MD</i>   |  | 10b. County<br><i>Baltimore</i>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><i>656 Kittendale Circle</i>  |  | 10f. Zip Code<br><i>21220</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:<br>Specify: <i>White</i> | 14. Race - American Indian, Black, White, etc.   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>12</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Base Facility Manager</i>   |  | 16b. Kind of Business/Industry<br><i>Air National Guard</i>  |
| 17. Father's Name (First, Middle, Last)<br><i>Flavydale Coffman</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Shirley Shipp</i>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Georgina Coffman - Spouse</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>656 Kittendale Circle, Middle River, MD 21220</i>   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:<br><i>Bayview Crematory</i>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Bayview Crematory</i>  | Date<br><i>5/12/12</i>   | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>  |
| 21. Signature of Funeral Service Licensee<br><i>G. Coffman</i>  |  | 22. Name and Address of Facility<br><i>Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Rd. 21222</i>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |
| a. <b>Combined Drug (Diazepam &amp; Morphine Intoxication)</b><br>Due to (or as a consequence of):  |  |   |  |  |
| b. _____<br>Due to (or as a consequence of):  |  |   |  |  |
| c. _____<br>Due to (or as a consequence of):  |  |   |  |  |
| d. _____  |  |   |  |  |
| <input checked="" type="checkbox"/> UNPENDED  |  | <input type="checkbox"/> AMENDED 23a, 27, 28a-f, per me, g927 5-23-12 sm  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><i>fd 5-7-12</i>  | 28b. Time of Injury<br><i>fd 11:35 am</i>  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br><i>unknown</i>     |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) <i>Residence</i>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>656 Kittendale Cir. Middle River, MD.</i>  |  |  |
| 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Theodore M. King, Jr., MD.</i>  |  | 29c. License number<br>O.C.M.E. OCME  |  | 29d. Date signed (Month, Day, Year)<br><i>May 8, 2012</i>  |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 16 2012</i>   |  | 32. Registrar's Signature<br><i>James J. Farley</i>   |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15490

1 - For  
State  
Registrar

|  |  |   |   |  |  |   |  |   |   |  |  |
|--|--|---|---|--|--|---|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Elnora Cole</b>   |   |   |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>14</b> Year <b>2012</b>                         | 3. Time of Death<br><b>10:36 A M</b>                         |   |   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Arlington West Nursing Home</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death   |  |   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>421-24-5431</b>  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b> | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months<br><b>88</b>   | If Under 24 Hrs.<br>Hours<br><b>0</b>  | Min.<br><b>0</b>  | 8. Date of Birth<br>(Month/Day/Year)<br><b>01/12/1924</b>    | 9. Birthplace (State or Foreign<br>Country)<br><b>Alabama</b>   |   |  |  |
|  | Usual Residence of Decedent<br>10a. State <b>MD</b> 10b. County <b>Baltimore</b>   |   |   | 10c. City, Town or Location<br><b>Windsor Mill</b>   |  |   |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |   |  |  |
| To Be Completed by Funeral Director                                | 10e. Street and Number<br><b>3314 Greenmeade Road</b>  |   |   | 10f. Zip Code<br><b>21244</b>  |  |   | 10g. Citizen of What Country?<br><b>USA</b>                  |   |   |  |  |
|  | 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b><br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:<br><b></b> |   |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b>  |   |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Seconday (0-12) 12</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>College (1-4 or 5+)</b>  |  | 16b. Kind of Business Industry<br><b>Seamstress</b>  |   |  | Garment   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Melton</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alberta Rutledge</b>   |   |  |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eleanor Crawley / Granddaughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3314 Greenmeade Road, Windsor Mill, MD 21244</b> |  |   |  |   |   |  |  |
|  | 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>  |  | Date<br><b>5/16/2012</b>  | 20c. Location - City or Town, State<br><b>Beltsville, MD</b> |   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Dorota Marshall</b>  |   |   | 22. Name and Address of Facility<br><b>Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203</b>  |  |   |  |   |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac arrhythmias</b>   |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>15 minutes</b>   |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertensive heart disease</b>  |   |   |  |  |   |  |   | 10 yrs  |  |  |
|  | b. Due to (or as a consequence of)<br><b>Congestive heart failure</b>  |   |   |  |  |   |  |   | 5 yrs   |  |  |
|  | c. Due to (or as a consequence of)<br><b>Chronic atrial Fibrillation</b>   |   |   |  |  |   |  |   | 1 yr  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy</b><br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown        |  |  |   |  | 23d. Date of delivery<br>Month Day Year   |   |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |   |   |  |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b> |  |  |
|  |  |   |   |  |  |   |  |   | 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  |
|  |  |   |   |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |  |  |
|  | 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |  |   |  |   |   |  |  |
|  | 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b><br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)<br><b>May</b>  |  | 28b. Time of injury<br><b>M</b>  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> | 28d. Describe how injury occurred                            |   |   |  |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>  |   |  |   |   |  |  |
|  | 29a. Certifier<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>(Check only one)</b><br><b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b><br><b>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   | 29c. License number<br><b>030494</b>  |  |  |   |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-15-2012</b>   |  |  |
|  | 29b. Signature and title of certifier<br><b>Dorothy S. Marshall</b>  |   |   |  |  |   |  |   |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dorothy S. Marshall 716 Maiden Choice Lane Baltimore MD 21228</b>   |   |   |  |  |   |  |   |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |   | 32. Registrar's Signature<br><b>Susan S. Parker</b>   |  |  |   |  |   |   |  |  |

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2012 1549

**1 - For  
State  
Registrar**

|  |  |                               |   |  |   |                                     |  |  |  |  |   |  |
|--|--|-------------------------------|---|--|---|-------------------------------------|--|--|--|--|---|--|
| <b>Physician/<br/>Medical<br/>Examiner</b>                               | 1. Decedent's Name (First, Middle, Last)<br><b>Dolores Elaine Becker Collins</b>   |                               |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> , Year <b>2012</b>   | 3. Time of Death<br><b>5:48 p M</b> |  |  |  |  |   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospice Center</b>  |                               | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |  | 4c. County of Death<br><b>Carroll</b>   |                                     |  |  |  |  |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>212-34-4523</b>  |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.   |                                     | If Under 1 Year<br>Months      Days      Hours      Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 21, 1934</b>                                     |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | 10a. State<br><b>MD</b>  |                               | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Reisterstown</b>  |                                     |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
| <b>To Be Completed by Funeral Director</b>                               | 10e. Street and Number<br><b>130 Lampert Road</b>  |                               |   |  | 10f. Zip Code<br><b>21136</b>   |                                     | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No      Specify:  |                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |
| <b>Physician/<br/>Medical<br/>Examiner</b>                               | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)      College (1-4 or 5+)<br><b>12</b>  |                               | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>                          |  | 16b. Kind of Business/Industry<br><b>Library</b>  |                                     |  |  |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward A. Becker</b>   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Ruth Sturtt</b>  |  |   |                                     |  |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark Jason Collins Son</b>  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3671 Old Taneytown Road Taneytown, MD 21787</b>   |  |   |                                     |  |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br><b>Lake View Mem. Park</b>  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Mem. Park</b>  |  | Date<br><b>5/15/2012</b>  |                                     | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>   |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD 21136</b>   |  |   |                                     |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b>   |                               |   |  | Approximate Interval Between Onset and Death  |                                     |  |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |                               |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |                                     | 23d. Date of delivery<br>Month      Day      Year  |  |  |  |   |  |
|  |  |                               |   |  |   |                                     | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  |   |                                     |  |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                               |   |  | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |                                     | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                    |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined<br>4 <input type="checkbox"/> Homicide   |                               | 28a. Date of injury<br>(Month, Day, Year)   |  | 28b. Time of injury<br>M  |                                     | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                               |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                     |  |  |  |  |   |  |
| <b>Medical Certificate To Be Completed by Physician/Medical Examiner</b> | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                               | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>DOOS 1119</b>   |                                     | 29d. Date signed (Month, Day, Year)<br><b>MAY 10, 2012</b>   |  |  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>UDAY B NANAVATY, MD CARROLL HOSPITAL CENTER, WESTMINSTER, MD</b>  |                               |   |  |   |                                     |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>                  |  | 32. Registrar's Signature<br> |   |  |   |                                     |  |  |  |  |   |  |

**Baltimore, Maryland 21215-0036**

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15492

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John A. Cunningham</b>   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>16</b> Year <b>2012</b>  |  | 3. Time of Death<br><b>05 18 AM</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>404-48-0538</b>   |  | 6. Sex<br><b>1 X M 2 F</b>   | 7. Age (in yrs. last birthday)<br><b>74 Yrs.</b> | If Under 1 Year<br>Months      Days      Hours      Min.   |
| Usual Residence of Decedent<br><b>MD N/A</b>  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>11/20/1937</b>  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |
| 10e. Street and Number<br><b>2307 Ashburton St.</b>   |  | 10f. Zip Code<br><b>21216</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:<br><b>Black</b> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>unk</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Analyst</b>   |  | 16b. Kind of Business/Industry<br><b>NSA</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>Bernard Cunningham</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Estella Jones</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret M. Cunningham (wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2307 Ashburton St., Baltimore, MD 21216</b>  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>   |  | Date<br><b>05/16/12</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Jacqueline E. Boane</b>   |  | 22. Street and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home PA<br/>2140 N. Fulton Ave., Baltimore, MD 21217</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | Approximate Interval Between Onset and Death   |  |  |
| a. <b>Intraoperative Sarcoma</b><br>Due to (or as a consequence of):  |  | <b>14 days</b>   |  |  |
| b. Due to (or as a consequence of):   |  |  |  |  |
| c. Due to (or as a consequence of):   |  |  |  |  |
| d. Due to (or as a consequence of):   |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown          |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC KIDNEY DISEASE Stage IV</b><br><b>CORONARY ARTERY DISEASE</b><br><b>CONGESTIVE HEART FAILURE</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury<br>M                         | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Karen M.</b>  |  | 29c. License number<br><b>RES 000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 10, 2012</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KATHLEEN OCTAVIEC MD SINAI HOSPITAL OF BALTIMORE Balt, MD 21215</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>  |  |  |
|   |  | 32. Registrar's Signature<br><b>Karen J. Parker</b>  |  |  |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2012 15493

|                                     |  |  |  |   |  |   |   |   |   |  |
|-------------------------------------|--|--|--|---|--|---|---|---|---|--|
| 1 - For State Registrar             |  | Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death   |   | 3. Time of Death                        |   |   |  |
| Physician/<br>Medical<br>Examiner   |  | Garrett Carey  |  |   | Month Day Year   |   | 730 AM                                  |   |   |  |
| Funeral<br>Director                 |  | 4a. Facility Name (if not institution, give street and number)<br>The Johns Hopkins Hospital   |  |   | 4b. City, Town, or Location of Death<br>Baltimore City   |   | 4c. County of Death<br>N/A              |   |   |  |
| To Be Completed by Funeral Director |  | 5. Social Security Number<br>218-58-6341   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>60 Yrs.   | If Under 1 Year<br>Months Days Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>04/15/1952   |   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   |  |
|                                     |  | Usual Residence of Decedent  |  |   | 10c. City, Town or Location<br>Baltimore   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
|                                     |  | 10a. State<br>MD   |  |   | 10b. County<br>N/A   |   |   |   |   |  |
|                                     |  | 10e. Street and Number<br>1208 W. Mosher St.   |  |   | 10f. Zip Code<br>21217   |   | 10g. Citizen of What Country?<br>U.S.A. |   |   |  |
|                                     |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |   |  |
|                                     |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th Grade  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+)<br>Never Worked   |   |   | 16b. Kind of Business/Industry<br>N/A   |   |  |
|                                     |  | 17. Father's Name (First, Middle, Last)<br>Norman Carey  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lementer Sample   |   |   |   |   |  |
|                                     |  | 19a. Informant's Name/Relationship (Type, Print)<br>Carolyn Carey (sister)   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1208 W. Mosher St., Baltimore, MD 21217   |   |   |   |   |  |
|                                     |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>on-site Crematory  |   | Date<br>05/15/12                        | 20c. Location - City or Town, State<br>Baltimore, MD  |   |  |
|                                     |  | 21. Signature of Funeral Service Licensee<br>Dietrich N. Williams  |  |   | 22. Name and Address of Facility<br>Joseph H. Brown Jr. Funeral Home PA<br>140 N. Fulton Ave.; Baltimore, MD 21217   |   |   |   |   |  |
| Physician/<br>Medical<br>Examiner   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Cerebral herniation  |  |   |  |   |   | Approximate Interval Between Onset and Death  |   |  |
|                                     |  | b. Due to (or as a consequence of):<br>epidural hematoma   |  |   |  |   |   |   |   |  |
|                                     |  | c. Due to (or as a consequence of):  |  |   |  |   |   |   |   |  |
|                                     |  | d. Due to (or as a consequence of):  |  |   |  |   |   |   |   |  |
|                                     |  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)                              |   |   | 23d. Date of delivery<br>Month Day Year   |   |  |
|                                     |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |   |   |  |
|                                     |  |  |  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                     |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |  |
|                                     |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined   |  |   | 28a. Date of injury (Month, Day, Year)<br>4/18/2012  |   |   | 28b. Time of injury<br>1236 PM  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred<br>subject struck by bus |
|                                     |  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>roadway  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Fallsway and Monument St auto, Fallsway and Monument St 110 |   |  |
|                                     |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29c. License number<br>Res-000   |   |   | 29d. Date signed (Month, Day, Year)<br>May 2 2012   |   |  |
|                                     |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Cansa Morenay 1800 Orleans St Baltimore MD 21287   |  |   |  |   |   |   |   |  |
|                                     |  | 31. Date filed (Month, Day, Year)<br>MAY 16 2012   |  |   | 32. Registrar's Signature<br>Leanne J. Parker  |   |   |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

4/

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15494

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

|   |  |   |                                |  |   |  |       |      |                         |                 |
|---|--|---|--------------------------------|--|---|--|-------|------|-------------------------|-----------------|
| 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year  |                                | 3. Time of Death<br>Hour:Minute AM/PM  |   |  |       |      |                         |                 |
| <i>Benjamin Edward Davis Jr</i>   |  | MAY 13 2012   |                                | 4:15 PM  |   |  |       |      |                         |                 |
| 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |                                | 4c. County of Death  |   |  |       |      |                         |                 |
| <i>Northwest Nursing Home</i>   |  | <i>Baltimore</i>  |                                | <i>N/A</i>   |   |  |       |      |                         |                 |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | 8. Date of Birth<br>(Month, Day, Year)   |   | 9. Birthplace (State or Foreign Country)   |       |      |                         |                 |
| <i>212-46-6302</i>  |  | <input checked="" type="checkbox"/> M <input type="checkbox"/> F  | <i>65</i>                      | Yrs.   | Months  | Days   | Hours | Min. | <i>September 6 1946</i> | <i>Maryland</i> |
| 10a. State  |  | 10b. County   |                                | 10c. City, Town or Location  |   | 10d. Inside City Limits  |       |      |                         |                 |
| <i>Maryland</i>   |  | <i>N/A</i>  |                                | <i>Baltimore</i>   |   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |       |      |                         |                 |
| 10e. Street and Number  |  | 10f. Zip Code   |                                | 10g. Citizen of What Country?  |   |  |       |      |                         |                 |
| <i>3235 Phelps Lane</i>   |  | <i>21229</i>  |                                | <i>USA</i>   |   |  |       |      |                         |                 |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>African American</i>   |       |      |                         |                 |
| <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   |                                |  |   |  |       |      |                         |                 |
| 15. Decedent's Education<br>(Specify only highest grade completed)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)  |                                | 16b. Kind of Business/Industry   |   |  |       |      |                         |                 |
| <i>Elementary/Secondary (0-12) 12th</i>   |  | <i>STEEL WORKER</i>   |                                | <i>Bethlehem Steel</i>   |   |  |       |      |                         |                 |
| 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |                                |  |   |  |       |      |                         |                 |
| <i>Benjamin Edward Davis Sr.</i>  |  | <i>Hattie Moses</i>   |                                |  |   |  |       |      |                         |                 |
| 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |  |   |  |       |      |                         |                 |
| <i>TERRY DAVIS</i>  |  | <i>3235 Phelps Lane Baltimore, Maryland 21229</i>   |                                |  |   |  |       |      |                         |                 |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                | Date   | 20c. Location - City or Town, State   |  |       |      |                         |                 |
| <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>MT. Zion</i>   |  |   |                                | <i>May 17 2012</i>   | <i>Lansdowne, Maryland</i>  |  |       |      |                         |                 |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |                                |  |   |  |       |      |                         |                 |
| <i>Darley M. Wallace</i>  |  | <i>Darley M. Wallace Funeral Service<br/>3405 W. Franklin Street Baltimore, MD. 21229</i>   |                                |  |   |  |       |      |                         |                 |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)  |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                | 23c. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown                       |   | 23d. Date of delivery<br>Month Day Year  |       |      |                         |                 |
|   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |       |      |                         |                 |
|   |  |   |                                | 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |       |      |                         |                 |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)   |                                |  |   |  |       |      |                         |                 |
|   |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>55425</i> |                                |  |   |  |       |      |                         |                 |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury<br>(Month, Day, Year)   |                                | 28b. Time of injury<br>M   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |       |      |                         |                 |
|   |  |   |                                |  |   |  |       |      |                         |                 |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Willie B. MYERS, MD</i>   |                                | 29c. License number<br><i>DC55425</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>5/16/12</i>  |       |      |                         |                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  | 31. Date filed (Month, Day, Year)<br><i>MAY 16 2012</i>   |                                | 32. Registrar's Signature<br><i>Leanne P. Jacobs</i>   |   | 33. Date of issue (Month, Day, Year)<br><i>21228</i>   |       |      |                         |                 |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15495

1- For  
State  
Registrar**Physician/  
Medical  
Examiner**

|  |  |  |                               |   |  |   |  |  |   |
|--|--|--|-------------------------------|---|--|---|--|--|---|
|  |  | 1. Decedent's Name (First, Middle, Last)<br><b>Alverta L. Dennis</b>   |                               |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>11</b> Year <b>2012</b>   |  | 3. Time of Death<br><b>10:30a M</b>  |   |
|  |  | 4a. Facility Name (if not institution, give street and number)<br><b>13 Swan Street</b>  |                               |   |  | 4b. City, Town, or Location of Death<br><b>Aberdeen</b>   |  | 4c. County of Death<br><b>Harford</b>  |   |
|  |  | 5. Social Security Number<br><b>220-34-5972</b>  | 6. Sex<br><b>M</b>            | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | If Under 1 Year<br>Months      Days  | If Under 24 Hrs.<br>Hours      Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 24, 1937</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |
|  |  | Usual Residence of Decedent  |                               |   |  |   |  | 10d. Inside City Limits<br><b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/> |   |
|  |  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Harford</b> | 10c. City, Town or Location<br><b>Aberdeen</b>  |  |   |  |  |   |
|  |  | 10e. Street and Number<br><b>13 Swan Street</b>  |                               |   | 10f. Zip Code<br><b>21001</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                      |  |   |
|  |  | 11. Marital Status<br><b>Never Married</b> <input type="checkbox"/> <b>Married</b> <input type="checkbox"/><br><b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/><br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/> Specify:<br><b>Afro American</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:   |   |
|  |  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>12</b>   |                               | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>  |  | 16b. Kind of Business/Industry<br><b>Housekeeping</b>   |  |  |   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Allen Eugene Murphy</b>  |                               |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida V. Kennard</b>   |   |  |  |   |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronnie Dennis (son)</b>   |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>920 Cambridge Ave., Aberdeen, MD 21001</b> |   |  |  |   |
|  |  | 20a. Method of Disposition<br><b>Burial</b> <input checked="" type="checkbox"/> <b>Cremation</b> <input type="checkbox"/> <b>Removal from State</b> <input type="checkbox"/><br><b>Donation</b> <input type="checkbox"/> <b>Other (Specify)</b> <input type="checkbox"/>   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Calvary Cemetery</b>   |  | Date<br><b>5/16/2012</b>  | 20c. Location - City or Town, State<br><b>Aberdeen, Maryland</b> |  |   |
|  |  | 21. Signature of Funeral Service Licensee<br><i>Kirkendall殡仪馆</i>  |                               | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.</b><br><b>Aberdeen, Maryland 21001</b>  |  |   |  |  |   |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)   |                               | 23b. Due to (or as a consequence of):<br><i>Acute myocardial infarct.</i>   |  |   |  | Approximate Interval Between Onset and Death   |   |
|  |  | 23c. If yes, outcome of pregnancy<br><b>Live Birth</b> <input type="checkbox"/> <b>Fetal death</b> <input type="checkbox"/> <b>Ectopic pregnancy</b> <input type="checkbox"/><br><b>Pregnant at time of death</b> <input type="checkbox"/> <b>Other (specify)</b> <input type="checkbox"/><br><b>Unknown</b> <input type="checkbox"/>  |                               | 23d. Date of delivery<br>Month      Day      Year   |  |   |  |  |   |
|  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Probably</b> <input type="checkbox"/> <b>Unknown</b> <input checked="" type="checkbox"/>   |                               | 23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |
|  |  | 24a. Was an autopsy performed?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>  |  |   |  |  |   |
|  |  | 25. Was case referred to medical examiner?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>  |                               | 26. Place of Death (Check only one)<br><b>Hospital</b> <input type="checkbox"/> <b>Inpatient</b> <input type="checkbox"/> <b>ER/Outpatient</b> <input type="checkbox"/> <b>DOA</b> <input type="checkbox"/> <b>Other</b> <input type="checkbox"/> <b>Nursing Home</b> <input checked="" type="checkbox"/> <b>Residence</b> <input type="checkbox"/> <b>Other (Specify)</b> <input type="checkbox"/> |  |   |  |  |   |
|  |  | 27. Manner of Death<br><b>Natural</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/><br><b>Pending Investigation</b> <input type="checkbox"/> <b>Could not be determined</b> <input type="checkbox"/>   |                               | 28a. Date of injury<br>(Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>  | 28d. Describe how injury occurred                                |  |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |
|  |  | 29a. Certifier<br><b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>Certifying Nurse Practitioner</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                               | 29b. Signature and title of certifier<br><i>Thomas A. Browne MD</i>   |  |   |  | 29c. License number<br><b>D42800</b>   | 29d. Date signed (Month, Day, Year)<br><b>5/16/12</b> |
|  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Thomas A. Browne 251 Lewis Hall, #609, Aberdeen, Maryland 21001</i>   |                               | 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |  |   |  | 32. Registrar's Signature<br><i>Thomas A. Browne</i>   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15496

1 - For  
State  
Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Antonietta DiMassimantonio

2. Date of Death

Month 5 Day 11 Year 2012

3. Time of Death

6:45 PM

4a. Facility Name (if not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-56-5631

6. Sex

M

F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 7, 1929

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

MD

10a. State

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

3710 Mary Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 5 College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Nicola DiGiacomo

18. Mother's Name (First, Middle, Maiden Surname)

Raphaela Picare

19a. Informant's Name/Relationship (Type, Print)

Nicolino DiMassimantonio / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3710 Mary Avenue; Baltimore, MD 21206

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

5/15/2012

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*John R. Pyrgos*

22. Name and Address of Facility

1050 York Road  
Ruck Towson Funeral Home, Inc. Towson, MD 21204

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. *Respiratory Failure*  
Due to (or as a consequence of):

b. *Polyneuropathy*  
Due to (or as a consequence of):

c. *Myopathy*  
Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No  
 Unknown

23c. If yes, outcome of pregnancy

Live Birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify) \_\_\_\_\_  
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Congestive Heart Failure*

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

*Aortic Aneurysm*

24a. Was an autopsy performed?

Yes  No

*Arteriovascular Disease*

24b. Were autopsy findings available prior to completion of cause of death?

Yes  No

25. Was case referred to medical examiner?

Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural  Pending Investigation  
 Accident  Could not be determined  
 Suicide  
 Homicide

28a. Date of injury (Month, Day, Year)

M

28b. Time of injury

M

28c. Injury at work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*John R. Pyrgos*

D 62099

29c. License number

MAY 11, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George John Pyrgos, MD 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAY 16 2012

32. Registrar's Signature

*Leanne S. Parks*

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2012 15497

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

|  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Bruce Leon Edwards</i>  |  |  | 2. Date of Death<br>Month <input checked="" type="checkbox"/> 5 Day <input type="checkbox"/> 12 Year <input type="checkbox"/> 12 1939 PM              |  | 3. Time of Death<br><input type="checkbox"/>                   |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>VA Loch Raven CLC</i>   |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><input type="checkbox"/>                |  |
| 5. Social Security Number<br><i>438-76-6319</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>62 Yrs.   | If Under 1 Year<br>Months <input type="checkbox"/><br>Days <input type="checkbox"/><br>Hours <input type="checkbox"/><br>Min. <input type="checkbox"/>   | 8. Date of Birth<br>(Month, Day, Year)<br><i>April 3, 1950</i> | 9. Birthplace (State or Foreign Country)<br><i>Louisiana</i>               |
| Usual Residence of Decedent<br>10a. State<br><i>Maryland</i>   |  |  | 10b. County<br><i>Howard</i>  |  |  | 10c. City, Town or Location<br><i>Columbia</i>                             |
| 10e. Street and Number<br><i>9725 Clocktower Lane</i>  |  |  | 10f. Zip Code<br><i>21046</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><i>Navy</i> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Specify:<br><i>Black</i> |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><i>Black</i> |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br><i>Elementary/Seconday (0-12)</i>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Docket Chief</i>                              |   | 16b. Kind of Business Industry<br><i>Department of Veterans Affairs</i>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Atha L. Edwards</i>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Vernida H. Hadley</i>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Toledo Edwards (Wife)</i>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9725 Clocktower Lane Columbia, Maryland 21046</i> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><i>► 711SFHark MO1050</i> |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Arlington National Cem</i>   |  | Date<br><i>unk</i>   | 20c. Location - City or Town, State<br><i>Arlington, Virginia</i>          |
| 21. Signature of Funeral Service Licensee<br><i>► 711SFHark MO1050</i>   |  |  | 22. Name and Address of Facility<br><i>Witzke Funeral Homes, Inc.<br/>5555 Twin Knolls Road Columbia, Maryland 21045</i>                              |  |  |  |

|  |  |  |  |   |
|--|--|--|--|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) |  | 23b. Due to (or as a consequence of):<br><i>Cirrhosis of Liver</i> |  | Approximate Interval Between Onset and Death<br><i>in Known</i> |
| 23c. Secondary but contributing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | 23d. Due to (or as a consequence of):                              |  |   |
| 23e. Due to (or as a consequence of):  |  | 23f. Due to (or as a consequence of):                              |  |   |
| 23g. Due to (or as a consequence of):  |  | 23h. Due to (or as a consequence of):                              |  |   |

|  |  |   |  |  |
|--|--|---|--|--|
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month <input type="checkbox"/><br>Day <input type="checkbox"/><br>Year <input type="checkbox"/> |
|--|--|---|--|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|--|--|--|--|

|   |  |   |
|---|--|---|
| 23f. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|---|

|                                   |  |
|-----------------------------------|--|
| 23h. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23i. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23j. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23k. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23l. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23m. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23n. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23o. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23p. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23q. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23r. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23s. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23t. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23u. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23v. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23w. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23x. Describe how injury occurred |  |
|-----------------------------------|--|

|  |  |
|--|--|
| 23y. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|

|                                   |  |
|-----------------------------------|--|
| 23z. Describe how injury occurred |  |
|-----------------------------------|--|

|   |  |
|---|--|
| 23aa. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23bb. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23cc. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23dd. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ee. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ff. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23gg. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23hh. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ii. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23jj. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23kk. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ll. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23mm. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23nn. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23oo. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23pp. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23qq. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23rr. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ss. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23tt. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23uu. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23vv. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ww. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23xx. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23yy. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23zz. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23aa. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23bb. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23cc. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23dd. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ee. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ff. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23gg. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23hh. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ii. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23jj. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23kk. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ll. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23mm. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23nn. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23oo. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23pp. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23qq. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23rr. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ss. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23tt. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23uu. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23vv. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ww. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23xx. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23yy. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23zz. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23aa. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23bb. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23cc. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23dd. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ee. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ff. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23gg. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23hh. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ii. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23jj. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23kk. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ll. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23mm. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23nn. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23oo. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23pp. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23qq. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23rr. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ss. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23tt. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23uu. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23vv. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ww. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23xx. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23yy. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23zz. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23aa. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23bb. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23cc. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23dd. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ee. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23ff. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23gg. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23hh. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23ii. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

|                                    |  |
|------------------------------------|--|
| 23jj. Describe how injury occurred |  |
|------------------------------------|--|

|   |  |
|---|--|
| 23kk. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|---|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15498

1- For State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)

Bruce Wayne Eck

2. Date of Death

Month May Day 12 Year 2012

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

VA Loch Raven CLC

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

—

5. Social Security Number

213-46-2663

6. Sex

M  F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/03/1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

8346 Hillendale Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No Army  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Car Mechanic

16b. Kind of Business/Industry

Service

17. Father's Name (First, Middle, Last)

Emory Eck

18. Mother's Name (First, Middle, Maiden Surname)

Unkn.

19a. Informant's Name/Relationship (Type, Print)

Renee Rath / Step-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2200 Whitecomb Circle, Baltimore, MD 21234

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

5/16/2012

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Metastatic Rectosigmoid Adenocarcinoma

a. Due to (or as a consequence of):

{ b. c. d.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Unknown  Other (Specify) \_\_\_\_\_

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA

Other: 4  Nursing Home 5  Residence 6  Other (Specify)

Hospice

27. Manner of Death

Natural  Pending investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?  
 Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George E. Weeks III M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

May 12, 2012

29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Weeks III M.D. 3900 Loch Raven Blvd Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAY 16 2012

32. Registrar's Signature

Leanne J. Grace

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2012 15499

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lucille R. Elrod</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>10</b> , Year <b>2012</b>   |   | 3. Time of Death<br>3:30 pM  |
| 4a. Facility Name (if not institution, give street and number)<br><b>CR Care Assisted Living</b>  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |   | 4c. County of Death<br><b>Prince George</b>                                      |
| 5. Social Security Number<br><b>412-32-6802</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83 Yrs.</b>  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 15, 1928</b>                    |
| 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>   |  | If Under 1 Year<br>Months <b> </b> Days <b> </b>  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George</b>   |   | 10c. City, Town or Location<br><b>Laurel</b>                                     |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6103 Parkway Drive</b>   |   |  |
| 10f. Zip Code<br><b>20707</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:<br><b>White</b> |  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business Industry<br><b>WSSC</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Randy E. Holman/ Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10579 Holden Circle, Franktown, CO 80116</b>  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)<br><b>M01053</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>West Arundel Crem.</b>   | Date<br><b>May 13, 2012</b>   | 20c. Location - City or Town, State<br><b>Odenton, MD</b>                        |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility Donaldson Funeral Home, P.A.<br><b>313 Talbott Ave., Laurel, MD 20707</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Advanced Age</b><br><b>Severe Alzheimer's Disease.</b>  |  |   |   |  |
| Approximate Interval Between Onset and Death  |  |   |   |  |
| <p>a. Due to (or as a consequence of):<br/> <b>Advanced Age</b></p> <p>b. Due to (or as a consequence of):<br/> <b>Severe Alzheimer's Disease.</b></p> <p>c. Due to (or as a consequence of):<br/> <b> </b></p> <p>d. Due to (or as a consequence of):<br/> <b> </b></p>  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown                           |   |  |
|   |  | 23d. Date of delivery<br>Month Day Year   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b> |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | 28d. Describe how injury occurred<br><b> </b>   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D52861</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 12, 2012</b>                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Asha Vali, MD, 12640 Clarksville Pike, Clarksville, MD 21029</b>   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 16 2012</b>   |  | 32. Registrar Signature<br>   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2012 15500

1 - For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Division of Vital Records, P.O. Box 68760

|   |                     |  |  |  |  |
|---|---------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)  |                     | 2. Date of Death   |  | 3. Time of Death                             |  |
| <b>JOSEPH FUNK</b>  |                     | <b>May 13 2012</b>   |  | <b>3:08 PM</b>                               |  |
| 4a. Facility Name (if not institution, give street and number)  |                     | 4b. City, Town, or Location of Death   |  | 4c. County of Death                          |  |
| <b>8072 Castle Rock Ct</b>  |                     | <b>Pasadena</b>  |  | <b>Anne Arundel</b>                          |  |
| 5. Social Security Number   |                     | 6. Sex   | 7. Age (In yrs. last birthday)   | 8. Date of Birth (Month, Day, Year)          |  |
| <b>215-46-6339</b>  |                     | <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  | <b>64 Yrs.</b>   | <b>7/15/47</b>                               |  |
| 9. Usual Residence of Decedent  |                     | 10. Inside City Limits   |  |  |  |
| 10a. State  | 10b. County         | 10c. City, Town or Location  |  |  |  |
| <b>MD</b>   | <b>Anne Arundel</b> | <b>Pasadena</b>  |  |  |  |
| 10e. Street and Number  |                     | 10f. Zip Code  | 10g. Citizen of What Country?  |  |  |
| <b>8072 Castle Rock Ct</b>  |                     | <b>21122</b>   | <b>USA</b>   |  |  |
| 11. Marital Status  |                     | 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  | 14. Race - American Indian, Black, White, etc.                               |
| <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>  |                     | <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b><br>If Yes, Give Year or Dates: <b>66-69</b>   | <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify:                      |  | <b>White</b>   |
| 15. Decedent's Education (Specify only highest grade completed)   |                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  |  | 16b. Kind of Business/Industry   |
| <b>Elementary/Secondary (0-12) 12</b>   |                     | <b>College (1-4 or 5+) 0</b>   |  |  | <b>Truck Driver</b>  |
| 17. Father's Name (First, Middle, Last)   |                     |  | 18. Mother's Name (First, Middle, Maiden Surname)  |  |  |
| <b>Charles Funk, Sr.</b>  |                     |  | <b>Iva Lint</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)  |                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |
| <b>Tina L. Hartlove/Daughter</b>  |                     | <b>8072 Castle Rock Ct, Pasadena MD 21122</b>  |  |  |  |
| 20a. Method of Disposition  |                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date   | 20c. Location - City or Town, State  |
| <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |                     | <b>Crownsville Veterans Cem.</b>   |  | <b>5/18/2012</b>                             | <b>Crownsville MD</b>  |
| 21. Signature of Funeral Service Licensee   |                     | 22. Name and Address of Facility   |  |  |  |
| <b>Victor P. Doda</b>   |                     | <b>Charles L. Stevens Funeral Home, Inc.</b><br><b>1501 E. Fort Avenue, Baltimore MD 21230</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                     |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |                     |  |  |  |  |
| <p>a. Due to (or as a consequence of): <b>LIVER Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>   |                     |  |  |  |  |
| Approximate Interval Between Onset and Death  |                     |  |  |  |  |
| IF FEMALE:  |                     | 23c. If yes, outcome of pregnancy  |  |  | 23d. Date of delivery  |
| 23b. Was decedent pregnant in the past 12 months?   |                     | 1 <input type="checkbox"/> Live Birth  | 2 <input type="checkbox"/> Fetal death   | 3 <input type="checkbox"/> Ectopic pregnancy | Month Day Year   |
| <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>  |                     | <b>4 <input type="checkbox"/> Pregnant at time of death</b>  | <b>5 <input type="checkbox"/> Other (specify)</b>  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                     |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?  |                     |  |  |  |  |
| <p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed?</p>   |                     |  |  |  |  |
| <p>24b. Were autopsy findings available prior to completion of cause of death?</p> <p>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p>   |                     |  |  |  |  |
| 25. Was case referred to medical examiner?  |                     | 26. Place of Death (Check only one)  |  |  |  |
| <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |                     | <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</p> <p>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> |  |  |  |
| 27. Manner of Death   |                     | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury  | 28c. Injury at work?                         | 28d. Describe how injury occurred  |
| <p>1 <input checked="" type="checkbox"/> Natural</p> <p>2 <input type="checkbox"/> Accident</p> <p>3 <input type="checkbox"/> Suicide</p> <p>4 <input type="checkbox"/> Homicide</p> <p>5 <input type="checkbox"/> Pending Investigation</p> <p>6 <input type="checkbox"/> Could not be determined</p>  |                     |  |  |  |  |
|   |                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier  |                     | 29c. License number  |  |  |  |
| <p>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> |                     | <b>DI 5872</b>   |  |  |  |
| 29b. Signature and title of certifier   |                     | 29d. Date signed (Month, Day, Year)  |  |  |  |
| <b>Dr. John R. Moore</b>  |                     | <b>May 15 2012</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |                     |  |  |  |  |
| <b>Dr. John R. Moore 6934 Aviation Blvd Glen Burnie MD 21061</b>  |                     |  |  |  |  |
| 31. Date filed (Month, Day, Year)   |                     | 32. Registrar's Signature  |  |  |  |
| <b>MAY 16 2012</b>  |                     | <b>Anna J. Parker</b>  |  |  |  |